Nos. 91-744 and 91-902

Supreme Court, U.S.
FILED
MAR 6 1992
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, REPRODUCTIVE HEALTH AND COUNSELING CENTER, WOMEN'S HEALTH SERVICES, INC., WOMEN'S SUBURBAN CLINIC, ALLENTOWN WOMEN'S CENTER, and THOMAS ALLEN, M.D., on behalf of himself and all others similarly situated,

Petitioners and Cross-Respondents,

—v.—

ROBERT P. CASEY, ALLAN S. NOONAN, and ERNEST D. PREATE, JR., personally and in their official capacities,

Respondents and Cross-Petitioners.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

JOINT APPENDIX
VOLUME I

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PETITION FOR CERTIORARI (NO. 91-744) FILED NOVEMBER 7, 1991
PETITION FOR CERTIORARI (NO. 91-902) FILED DECEMBER 9, 1991
CERTIORARI GRANTED JANUARY 21, 1992

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The following opinions and orders have been omitted in printing this Joint Appendix because they appear on the following pages in the Appendix to the Petition for a Writ of Certiorari in No. 91-744.

Planned Parenthood v. Casey, 947 F.2d 682
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(E.D. Pa. 1990) 104a

Order of the United States District Court
for the Eastern District of Pennsylvania,
filed August 24, 1990 .....285a

RELEVANT DOCKET ENTRIES
United States District Court for the Eastern District of Pennsylvania (No. 88-3228)

No.	Date		Discription of Entry
	1988 Apr		
1	"	18	Complaint, filed.
"	"	18	Summons exit (given to counsel).
2	"	18	MOTION AND ORDER APPOINTING NICK VINCI TO SERVE SUMMONS AND COMPLAINT UPON DEFT MICHAEL MARINO, FILED. 4/18/88: Entered and copy given
3	"	18	MOTION AND ORDER APPOINTING TOM SPEAKER TO SERVE SUMMONS AND COMPLAINT UPON DEFTS CASEY, RICHARDS & ZIMMERMAN, FILED. 4/18/88: Entered and copy given
4	"	20	PLFFS' MOTION FOR TEMPORARY RESTRAINING ORDER, MEMO., CERT OF SERVICE, FILED.
5	"	20	Summons returned with Affidavit of Tom Speaker re: served Dee Lynch, receptionist, Office of the Governor on 4/19/88; Jonathan Neipris, Chief Counsel, PA Dept of Health on 4/19/88; Naida Huber, receptionist, Office of Attorney General on 4/19/88; and affidavit of Nicholas Vinci re: served Ann Fleer, Secretary to Michael e. Marino, on 4/18/88, filed.

6	"	21	Verification of James M. Bucci, Esq. and Barry Steinhardt, filed.
7	"	21	TEMPORARY RESTRAINING ORDER THAT DEFTS ARE ENJOINED & RESTRAINED FROM ENFORCING THE PROVISIONS OF SEC.3206 OF PA ABORTION CONTROL ACT OF 1982 UNTIL FURTHER ORDER OF COURT AND FROM PUBLICLY DISCLOSING, ETC., ANY REPORT FILED PURSUANT TO SEC. 3207(b) OR 3214(f) OF PA ABORTION CONTROL ACT OF 1982 UNTIL JURTHER ORDER OFTHIS COURT; THIS T.R.O. SHALL REMAIN IN EFFECT UNTIL 5/9/88. filed. 4/21/88: Entered and copies mailed.
8	"	21	ORDER THAT A PRELIMINARY INJUNCTION HEARING BE HELD 5/9/88 AT 10:00 A.M. ETC., FILED. 4/21/88: Entered and copies mailed.
9	"	22	Appearance of Gregory R. Neuhauser and Kate L. Mershimer on behalf of defts Robert P. Casey, N. Mark Richards & LeRoy Zimmerman, filed.
10	"	22	PLFFS' MOTION FOR PERLIMINARY INJUNCTION, MEMO., CERT OF SERVICE, FILED.
11	"	26	Hearing 4/21/88 re: application for T.R.O., filed.
12	"	27	DEFT'S MOTION FOR LEAVE TO APPEAR PRO HAC VICE, CERT OF SERVICE, FILED.
13	"	27	Plffs' Witness List, filed.

14	"	27	Plffs' Proposed Findings of Fact and Conclusions of Law for Determination of Motion for Preliminary Injunction, filed.
(12)	"	28	ORDER THAT GREGORY R. NEUHAUSER, ESQ. IS GRANTED LEAVE TO APPEAR AS COUNSEL FOR DEFTS PRO HAC VICE, FILED.
	May		
15	"	05	Stipulation of Uncontested Facts for Determination of Motion for Preliminary Injunction, filed.
16	"	05	Plff's Supplemental Memo in support of its motion for preliminary injunction, filed.
17	"	06	Ltr. from Deft's conusel for Judge Huyett, dtd 5/4/88, re: corrected table of content to Defts' memo in opposition to plffs' motion for preliminary injunction, filed.
18	"	09	ORDER THAT T.R.O. ISSUED 4/21/88 SHALL REMAIN IN EFFECT UNTIL RULING ON MOTION FOR PRELIMINARY INJUNCTION, ETC., FILED. 5/10/88: Entered and copies mailed.
19	"	09	Ltr. from Frederic Wentz, Counsel to M. Marino, to Judge Huyett, dtd 5/3/88, re: does not plan to participate in this matter, filed.
20	"	10	Answer of Defts Casey, Richards and Zimmerman, filed.
--	"	10	ISSUE JOINED.
21	"	11	Plffs' Exhibits to Plffs' Motion for Preliminary Injunction, filed.
22	"	11	Supplemental Declaration of Patricia Potrzebowski, Ph.D., filed.
23	"	13	Preliminary Injunc. Hearing 5/9/88, witnesses sworn, Court rules C.A.V., filed.

24	"	23	FINDINGS OF FACTS, DIXCUSSION, CONCLUSIONS OF LAW AND PRELIMINARY INJUNCTION THAT DEFTS. ARE HEREBY ENJOINED FROM IMPLEMENTING OR ENFORCING ANY AND ALL PROVISIONS OF THE PENNA. ABORTION CONTROL ACT OF 1982 ETC., FILED. 5/23/88 entered & copies mailed
25	"	25	DEFTS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW ON PLFFS' MOTION FOR PRELIMINARY INJUNCTION, CERTIFICATE, FILED.
26	"	25	Defts' memo of law in opposition to Plffs' motion for preliminary injunction, certificate, filed.
	Jun		
27	"	06	DEFTS' MOTION FOR CODIFICATION AND CLARIFICATION, CERTIFICATE, FILED.
28	"	14	ORDER THAT IN RESPECT TO FINDINGS OF FACT, DISCUSSION, CONCLUSIONS OF LAW & PRELIMINARY INJUNCTION ISSUED 5/23/88, THE DISCUSSION & PRELIMINARY INJUNCTION ORDER ARE AMENDED, NUNC PRO TUNC, ETC., FILED. 6/14/88: Entered and copies mailed.
29	"	22	Ltr. To Judge Huyett, dtd 6/13/88, from plff's Counsel, requesting para. 4 & 5 of Court's 5/23/88 Order be modified & amended, etc., filed.

30	"	22	ORDER THAT DEFTS' MOTION FOR MODIFICATION & CLARIFICATION OF THE PRELIMINARY INJUNCTION ISSUED 5/23/88 IS DENIED, FILED. 6/22/88: Entered and copies mailed.
	Jul		
31	"	22	DEFTS' MOTION FOR MODIFICATION OF PRELIMINARY INJUNCTION, CERT OF SERVICE, FILED.
32	"	27	ORDER THAT A STATUS CONFERENCE IS SCHEDULED FOR 8/9/88 AT 2 P.M., FILED. 7/28/88: Entered and copies mailed.
	Aug		
33	"	02	Plffs' Memo in response to Deft's Motion for modification of Preliminary Injunction, Cert of service, filed.
34	"	09	ORDER THAT THE STATUS CONF. SCHEDULED FOR 8/9/88 IS CANCELLED & RESCHEDULED FOR 8/22/88 AT 2 P.M., FILED. 8/9/88: Entered and copies mailed.
33	"	09	ORDER THAT THE PA DEPT OF HEALTH MAY DISTRIBUTE & UTILIZE ITS REVISED "REPORT OF INDUCED TERMINATION OF PREGNANCY" FORM FOR COLLECTION OF INFORMATION, ETC., FILED. 8/10/88: Entered and copies mailed
35	"	23	ORDER THAT ALL DISCOVERY BE COMPLETED BY 12/23/88 ETC., FILED. 8/23/88: Entered & copies mailed.

	Oct		
36	"	24	Withdrawal of appearance of Kathryn Kolbert, Esq. on behalf of plff, filed.
37	"	27	ORDER THAT THIS ACTION WILL BE MAINTAINED AS A CLASS ACTION ON BEHALF OF A CLASS OF PHYSICIAN PLFFS AS DEFINED, ETC.; PLFF THOMAS ALLEN, M.D. IS DESIGNATED CLASS REPRESENTATIVE & COUNSEL OF RECORD FOR PLFFS IN THIS ACTION ARE DESIGNATED AS COUNSEL FOR THE CLASS, FILED. 10/28/88: Entered and copies mailed.
	Dec		
38	"	07	Transcript of Hearing of 4-21-88, filed.
39	"	07	Transcript of hearing of 5-9-88, filed.
40	"	22	STIPULATION AND ORDER EXTENDING DISCOVERY TIME TO 2/23/89, ETC., FILED. 12/27/88 ENTERED AND COPIES MAILED
41	"	23	STIPULATION AND ORDER RE: CONFIDENTIAL MATERIAL; CONFIDENTIAL MATERIAL SHALL BE SUBMITTED & FILED IN A SEALED ENVELOPE, ETC., FILED. 12/27/88: Entered and copies mailed.
	1989		
	Feb		
42	"	01	DEFTS' MOTION TO FILE AMENDED RESPONSES TO PLFFS' REQUESTS FOR ADMISSION, BRIEF, CERT OF SERVICE, FILED.
43	"	06	Withdrawal of appearance of Gregory R. Neuhauser, Sr.Dpty, and appearance of John G. Knorr, III on behalf of defts, filed.

(42)	"	24	ORDER THAT DEFTS' MOTION TO FILE AMENDED RESPONSES TO PLFF'S REQUEST FOR ADMISSION IS GRANTED, ETC., FILED. 2/24/89: Entered and copies mailed.
	Mar		
44	"	03	ORDER THAT A TELEPHONE CONFERENCE IS SCHEDULED FOR 3/10/89 AT 3 P.M.; FILED. 3/3/89: Entered and copies mailed.
45	"	09	ORDER THAT THE TELEPHONE CONFERENCE SCHEDULED FOR 3/10/89 IS CONTINUED FOR 3/14/89 AT 3:00 P.M., FILED. 3/9/89: Entered and copies mailed
46	"	30	ORDER THAT ALL PROCEEDINGS ARE STAYED PENDING ISSUANCE OF THE DECISION OF THE U.S. SUPREME COURT IN WEBSTER ET AL VS. REPRODUCTIVE HEALTH SERVICES ET AL, NO. 88-605; FURTHER ORDER THAT ALL DISCOVERY SHALL BE COMPLETED WITHIN 30 DAYS OF PUBLICATION OF THE WEBSTER DECISION IN U.S. LAW WEEK, FILED. 3/30/89: Entered and copies mailed.
47	"	31	ORDER THAT THE CLERK MARK THIS ACTION CLOSED FOR STATISTICAL PURPOSES AND PLACE MATTER IN THE CIVIL SUSPENSE FILE, FILED. 4/3/89: Entered and copies mailed.

1990

Jan

48 " 11 Consent to file amended complaint, filed.
49 " 11 Amended complaint, filed.
50 " 12 ORDER THAT COURTS PRELIMINARY INJUNCTION OF 5/23/88 IS CLARIFIED ETC., FILED1/12/90 ENTERED AND COPIES MAILED
51 " 19 ORDER OF TRANSFER CASE OUT OF CIVIL SUSPENSE, FILED. 1/22/90 ENTERED AND COPIES MAILED
52 " 22 STIPULATION AND ORDER THAT DISCOVERY BE COMPLETED BY 3/27/90, ETC., FILED. 1/22/90 ENTERED AND COPIES MAILED
53 " 26 Answer of defts. Casey et al to amended complaint, filed.
54 " 26 DEPTS JOHN F. WHITE, JR. ET AL MOTION FOR A STAY, CERTIFICATE, FILED.

Mar

55 " 16 STIPULATION AND ORDER THAT DISCOVERY SHALL BE COMPLETED BY 4/30/90, FILED. 3/16/90 ENTERED AND COPIES MAILED
56 " 16 ORDER THAT THE STIPULATION OF COUNSEL SHALL BE SUPPLEMENTED AS FOLLOWS: THE PARTIES SHALL SUBMIT PROPOSED FINDINGS OF FACT ON ALL FACTS IN DISPUTE AND, IN ADDITION, CONCLUSIONS OF LAW ON OR BEFORE 5/31/90, ETC. FILED. 3/19/90 ENTERED AND COPIES MAILED

57 " 21 Notice of change of address of Thomas E. Zemaitis, esq, filed

May

58 " 10 JOINT MOTION FOR EXTENSION OF TIME, CERT. OF COUNSEL, CERT. OF SERVICE, FILED.
59 " 23 ORDER THAT THE PARTIES JOINT MOTION FOR EXTENSION OF TIME IS GRANTED IN PART AND DENIED IN PART. ALL DISCOVERY SHALL BE COMPLETED NOT LATER THAN JUNE 22, 1990, ETC., TRIAL SHALL TAKE PLACE ON JULY 30, 1990, ETC., FILED. 5/23/90 Entered and copies mailed.

Jun

60 " 25 DEFTS' MOTION TO COMPEL DISCOVERY, CERTIFICATE OF SERVICE, FILED.

Jul

61 " 03 Defts' praecipe to withdraw defts' motion to compel discovery, cert of service, filed.
62 " 06 Deft Casey, Richards, & Preate's proposed findings of fact and conclusions of law
63 " 06 Deft Casey, Richards, & Preate's Pretrial Brief, filed.
64 " 06 Plff's Stipulation of Uncontested Facts, filed.
65 " 06 Plffs' Proposed Findings of Fact & Conclusions of law, filed.
66 " 06 Plffs' Pretrial memo, filed.
67 " 16 ORDER THAT DEFTS' MOTION TO COMPEL DISCOVERY IS WITHDRAWN, FILED. 7-17-90 ENTERED & COPIES MAILED

68	"	16	Plffs' Pretrial memo of law, cert of service, filed.
69	"	18	ORDER OF UNCONTESTED FACTS, FILED. 7-19-90 ENTERED & COPIES MAILED
70	"	23	DEFTS' Casey, Richards & Preate's memo of law, filed.
71	"	24	Stipulation of Voluntary Dismissal of MICHAEL D. MARINO, FILED.
72	"	24	PLFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT RESPECTING SECTION 3210, MEMO, & CERT OF SERVICE, FILED.
73	"	25	Supplemental Stipulation of Uncontested Facts, filed. 8-3-90 ENTERED & COPIES MAILED.
74	"	31	Defts' Brief in opposition to plffs' motion for partial summary judgment, filed.
	Aug		
75	"	02	Trial resumes 7/31/90, filed.
76	"	02	ORDER THAT WITHIN 4 DAYS OF THE CLOSE OF EVIDENCE, PLFFS SHALL FILE REVISED OR SUPPLEMENTAL PROPOSED FINDINGS OF FACT & CONCLUSIONS OF LAW & A MEMO OF LAW IN REPLY TO DEFTS' MEMO OF LAW ON OR ABOUT 7-20-90 ETC., FILED. 8/3/90 ENTERED AND COPIES MAILED
77	"	02	ORDER THAT DEFTS' ORAL MOTION IN LIME TO EXCLUDE THE TESTIMONY OF MS. DILLON IS DENIED, FILED.
78	"	03	Trial 8/1/90; Witnesses sworn, filed.
79	"	06	Trial resumes 8/2/90, filed.

80	"	07	Plffs' revised proposed findings of fact & conclusions of law, filed.
81	"	07	Plffs' Post-trial memorandum of law, filed.
82	"	10	Transcript of Status Conference 7/30/90, filed.
83	"	10	Transcript of non-jury trial 7/30/90 filed.
84	"	10	Transcript of non-jury trial 7/31/90, filed.
85	"	10	Transcript of non-jury trial 8/1/90, filed.
86	"	10	Transcript of non-jury trial 8/2/90 filed.
87	"	17	Defts revised proposed finds of fact and conclusions of law, filed.
88	"	17	DEFTS' SURREPLY BRIEF, FILED
89	"	24	OPINION AND ORDER THAT JUDGMENT IS ENTERED IN FAVOR OF PLFFS AND AGAINST DEFTS. DEFTS ARE PERMANENTLY ENJOINED FROM IMPLEMENTING AND ENFORCING ALL PROVISIONS OF THE PA. ABORTION CONTROL ACT OF 1982, AS EMENDED BY ACT 31 AND ACT 64, THAT CONTAIN THE TERM "MEDICAL EMERGENCY" AS DEFINED IN SECTION 3202 OF THE ACT. DEFTS ARE PERMANENTLY ENJOINED FROM IMPLEMENTING AND ENFORCING ANY AND ALL PROVISIONS OF SEC. 3205, 3206, 3209 OF THE PA. ABORTION CONTROL ACT OF 1982, AS AMENDED BY ACT 31 AND ACT 64. DEFTS ARE HEREBY PERMANENTLY ENJOINED FROM DISCLOSING OR OTHERWISE MAKING AVAILABLE FOR PUBLIC INSPECTION ANY REPORT THAT HAS BEEN FILED OR THAT MAY BE FILED PURSUANT TO SEC. 3207(b)

OR 3214(f) OF THE PA. ABORTION CONTROL ACT OF 1982, AS AMENDED BY ACT 31 AND 64. DEFTS ARE PERMANENTLY ENJOINED FROM IMPLEMENTING OR ENFORCING THE PROVISION OF SEC. 3214(a)(1), INSOFAR AS IT REQUIRES THE IDENTIFICATION OF THE REFERRING PHYSICIAN, ETC., DEFTS ARE HEREBY ENJOINED FROM DISTRIBUTING OR UTILIZING THE PA. REPORT OF INDUCED TERMINATION OF PREGNANCY EXCEPT IN A APPROPRIATE FORM CONSISTENT WITH THE DISCUSSION AND CONCLUSIONS OF LAW CONTAINED IN THE FOREGOING OPINION, FILED. 8/24/90 Entered and Copies mailed

90 " 24 ORDER THAT PLFFS MOTION FOR PARTIAL SUMMARY JUDGMENT IS DENIED, FILED. 8/24/90 Entered and copies mailed.

Sept

91 " 07 Defts' Notice of Appeal, filed. (USCA 901662) 9/7/90 copies to: Clerk, USCA Appeals Clerk, Judge Huyett, Susan Harrison, Esq.

92 " 07 Copy of Clerk's notice to USCA, filed.

93 " 17 Appellant's copy of TPO, filed.

-- " 18 RECORD COMPLETE FOR PURPOSES OF APPEAL-TRANSCRIPT ALREADY ON FILE

United States Court of Appeals
for the Third Circuit (No. 90-1662)

1990
Sept

94 " 11 CIVIL CASE DOCKETED. Notice filed by Robert P. Casey, N. Mark Richards & Ernest D. Preate, Jr. (ghb)

95 " 11 TRANSCRIPT (Clk), already on file in the District Court Clerk's Office. (ghb)

96 " 11 BRIEFING NOTICE ISSUED. Appellant brief and appendix due 10/22/90. (ghb)

97 " 13 LETTER MOTION dated: 9/12/90 by Appellants for extension of time to file brief and appendix, Certificate of Service dated 9/12/90. (dlr)

98 " 14 ORDER (Clerk) An extension to file appellants' brief until 11/1/90 is granted. No further extensions will be granted for any reason, filed. (dlr)

99 " 17 TRANSCRIPT PURCHASE ORDER (Part I), already on file in the District Court Clerk's Office, filed. (sdt)

100 " 18 CERTIFIED LIST filed. (ghb)

101 " 18 APPEARANCE from Attorney Thomas E. Zemaitis on behalf of Appellees Planned Parenthood, Reproductive Health & Counseling Center, Women's Health Services, Women's Suburban Clinc, Allentown Women's Center & Thomas E. Allen, M.D., filed. (ghb)

102 " 18 DISCLOSURE STATEMENT on behalf of Appellees Planned Parenthood, Reproductive Health & Counseling Center, Women's Health Services, Women's Suburban Clinic, Allentown

Women's Center & Thomas E. Allen, M.D., filed. (ghb)

103 " 21 APPEARANCE from Attorney Kate L. Mershimer on behalf of Appellants, filed.

104 " 21 INFORMATION STATEMENT on behalf of Appellants, RECEIVED. (ghb)

Oct

105 " 02 LETTER TO Attorney Roger K. Evans, Kathryn Kolbert, Susan Cary Nicholas, Linda J. Wharton requesting the following documents: **Appearance Form** Disclosure Statement. (ghb)

106 " 11 MOTION by Appellees to hold case in abeyance pending the U.S. Supreme Court's decision in Rust v. Sullivan, Nos. 89-1391 and 89-1392 (oral argument scheduled for 10-30-90) Second Circuit, 889 F.2d 401, filed. Certificate of Service dated 10/11/90. (emd)

107 " 22 RESPONSE by Appellants Robert P. Casey, N. Mark Richards, and Ernest D. Preate in opposition to Appellees' Motion to hold case in abeyance, filed. Certificate of service dated 10/19/90. (emd)

Nov

108 " 01 BRIEF on behalf of Appellant Robert P. Casey, Appellant N. Mark Richards, Appellant Ernest D. Preate, Pages: 50, Copies: 10, Delivered by mail, filed. Certificate of service date 11.1.90. (wab)

109 " 01 APPENDIX on behalf of Appellant Robert P. Casey, Appellant N. Mark Richards, Appellant Ernest D. Preate, Copies: 4 Volumes: 8, Delivered by mail, filed. Certificate of service dated 11/1/90. (wab)

110 " 05 MOTION filed by John E. McKeever, Esq., counsel for American Academy of Medical Ethics for leave to file an amicus curiae brief in support of Appellants and for leave to file instanter (out of time). Certificate of service dated 11/5/90. (emd)

111 " '06 ORDER filed (Becker and Greenberg, Circuit Judges) denying motion to hold case in abeyance by Appellee Thomas Allen, Allentown Womens Ctr, Womens Suburban, Womens Health Ser, Reproductive Health, Planned Parenthood. (rmg)

112 " 27 ORDER filed (Becker, Circuit Judge) granting motion by American Academy of Medical Ethics for leave to file an amicus curiae brief in support of Appellants and for leave to file instanter (out of time). (rmg)

113 " 27 AMICUS BRIEF on behalf of American Academy of Medical Ethics. Pages: 29, Copies: 10, Delivered by mail, filed. Certificate of service date 11/5/90 (see 11/27/90 order). (rfl)

114 " 27 APPEARANCE from Attorney John E. McKeever on behalf of Amicus-appellant American Academy of Medical Ethics, filed. (ghb)

115 " 27 DISCLOSURE STATEMENT on behalf of Amicus-appellant American Academy of Medical Ethics, filed. (ghb)

Dec

116 " 04 BRIEF on behalf of Appellee Planned Parenthood, Appellee Reproductive Health, Appellee Womens Health Ser,

Appellee Womens Suburban, Appellee Allentown Womens Ctr, Appellee Thomas Allen, Pages: 48, Copies: 10, Delivered by mail, filed. Certificate of Service dated 12/4/90. (rfl)

117 " 04 AMICUS BRIEF on behalf of The Pennsylvania Chapter of the American College of Emergency Physicians. Pages: 13, Copies: 10, Delivered by mail, filed. Certificate of service date 12/4/90. (rfl)

118 " 04 MOTION filed by PA Coalition, PA Coalition Against, Domestic Violence, Natl Woman Abuse, Natl Coalition, CT Coalition Against, NJ Coalition For, Clinton Cty Womens, Hospitality House, Laurel House, Tioga Cty Womens, Women Against, Women Against Abuse, Womens Center for leave to proceed as amicus curiae on behalf of appellees with consent. Certificate of Service dated 12/14/90. [No order necessary has written consent] (dlr)

119 " 07 MOTION filed by Amici Curiae-Appellees PA Coalition, PA Coalition Against, Domestic Violence, Natl Woman Abuse, Natl Coalition, CT Coalition Against, NJ Coalition For, Clinton Cty Womens, Hospitality House, Laurel House, Tioga Cty Womens, Women Against, Women Against Abuse, Womens Center for extension of time to file brief until 12/11/90. Certificate of service dated 12/4/90. (dlr)

120 " 10 ORDER (Clerk) granting motion by Amici Curiae, PA Coalition Against, et al., for extension to file amici brief until

12/11/90. Appellants are granted a three day extension to file their reply brief beyond the normal 14 day period, filed. (dlr)

121 " 11 AMICUS BRIEF on behalf of PA Coalition Against Domestic Violence, et al. Pages: 42, Copies: 10, Delivered by mail, filed. Certificate of service date 12/11/90. [See 12/10/90 order] [FILED BY CONSENT IN MOTION] (wab)

122 " 14 APPEARANCE from Attorney Phyllis Gelman on behalf of Amicus-appellees Pennsylvania Coalition Against Domestic Violence, Pennsylvania Coalition Against Rape, Domestic Violence Research and Resources, National Woman Abuse Prevention Project, National Coalition Against Domestic Violence, Connecticut Coalition Against Domestic Violence, New Jersey Coalition For Battered Women, Clinton County Women's Center, Hospitality House Services for Women, Inc., Laurel House Survivors, Inc., Tioga County Women's Coalition, Women Against Abuse, Inc., Women Against Abuse Legal Center, Inc. & Women's Center and Shelter of Greater Pittsburgh, filed. (ghb)

123 " 14 DISCLOSURE STATEMENT on behalf of Amicus-appellees Pennsylvania Coalition Against Domestic Violence, Pennsylvania Coalition Against Rape, Domestic Violence Research and Resources, National Woman Abuse Prevention Project, National Coalition Against Domestic Violence, Connecticut

Coalition Against Domestic Violence, New Jersey Coalition For Battered Women; Clinton County Women's Center, Hospitality House Services For Women, Inc., Laurel House Survivors, Inc., Tioga County Women's Coalition, Women Against Abuse, Inc., Women Against Abuse Legal Services, Inc. & Women's Center and Shelter of Greater Pittsburgh, filed. (ghb)

124 " 14 APPEARANCE from Attorney James Eiseman on behalf of Amicus-appellee Pennsylvania Chapter of the American College of Emergency Physicians, filed. (ghb)

125 " 14 DISCLOSURE STATEMENT on behalf of Amicus-appellee Pennsylvania Chapter of the American College of Emergency Physicians, filed. (ghb)

126 " 21 REPLY BRIEF on behalf of Appellant Robert P. Casey, Appellant N. Mark, Richards, Appellant Ernest D. Preate, Copies: 10, Delivered by mail, filed. Certificate of Service date 12/21/90. (rfl)

127 " 27 CALENDARED for Monday, February 25, 1991. (agb)

1991
Feb

128 " 20 Clerk's letter, written at the direction of the Court, requesting counsel be prepared at oral argument to comment on Marks v. United States, 430 U.S. 188 (1977), in the context of the question listed as Issue I at page 1 of Appellant's brief, etc. (sdt)

129 " 20 APPEARANCE from Attorney Kathryn Kolbert on behalf of Appellees Planned

Parenthood, Reproductive Health & Counseling Center, Women's Health Services, Women's Suburban Clinic, Allentown Women's Center & Thomas E. Allen, M.D., filed. (ghb)

130 " 25 ARGUED 2/25/91 Panel: Stapleton, Alito, Seitz, Circuit Judges. At oral argument Court directed counsel to have transcript of oral argument prepared. (agb)

Mar

131 " 13 Copy of transcript of tape of oral argument on 2/25/91 prepared at the direction of the Court. (sdt)

Jul

132 " 09 LETTER dated 7/9/91 pursuant to Rule 28(j) from Thomas E. Zemaitis, Esq., counsel for Appellee, with service, with enclosure, received. (emd)

133 " 26 LETTER dated 7/25/91 pursuant to Rule 28(j) from Kate L. Mershimer, Esq., counsel for Appellants, with service, received. (emd)

Oct

134 " 21 OPINION (Stapleton, Authoring Judge, Alito and Seitz, Circuit Judges), with a concurring and dissenting opinion by Judge Alito, filed. (bj)

135 " 21 JUDGMENT: AFFIRMED in part and REVERSED in part in accordance with the opinion of this Court, filed. (bj)

Nov

136 " 07 MOTION filed by Appellees, Planned Parenthood et al., to stay mandate. Certificate of Service dated 11/7/91. (bj)

137 " 12 Supreme Court of U.S. notice filed advising petition for writ of certiorari filed by Appellees, Planned Parenthood, et al., filed in the Supreme Court on 11/7/91 at Supreme Court, case number: 91-744. (anh)

138 " 19 RESPONSE by Appellants Robert P. Casey, et al. in opposition to Appellees' motion to stay mandate, received. Certificate of service dated 11/18/91. (bj)

139 " 20 APPELLEES' APPLICATION for Attorney's fees together with Memorandum in Support Thereof. Certificate of service dated 11/20/91, filed. (bj)

140 " 26 ORDER filed, (Stapleton, Circuit Judge) granting motion to stay mandate by Appellee Planned Parenthood. Mandate Stayed to 12/12/91. (bj)

141 " 26 APPELLANTS' MOTION TO STAY APPELLEES' APPLICATION FOR ATTORNEYS FEES, filed. Certificate of Service dated 11/25/91. (bj)

Dec

142 " 05 Appellants' Brief in Opposition to Appellees' Application for Attorney's Fees, received. Certificate of service dated 12/4/91. (bj)

143 " 16 Supreme Court of U.S. notice filed advising petition for writ of certiorari filed by Appellants, Robert P. Casey et al. Filed in the Supreme Court on 12/11/91 at Supreme Court. case 91-902. (bj)

144 " 30 ORDER filed (Stapleton, Authoring Judge, Alito and Seitz, Circuit Judges) granting motion to stay Application for

Attorneys Fees by Appellant, Ernest D. Preate, Jr., pending final disposition by the Supreme Court of the matter before it. (bj)

1992

Jan

145 " 16 REPORTER at 947 F2d: 682 (kot)

146 " 24 U.S. Supreme Court order dated 1/21/92 at S.C. number: 91-744, granting LIMITED petition for writ of certiorari by Appellee Planned Parenthood, Reproductive Health, Womens Health Ser, Womens Suburban, Allentown Womens Ctr, Thomas Allen, limited to following questions, definition of medical emergency, informed consent, spousal notice. This case is consolidated with S.C. No. 91-902, Casey, et al. (bj)

147 " 24 U.S. Supreme COurt order dated 1/21/92 at S.C. number: 91-902, granting LIMITED petition for writ of certiorari by Appellant Robert P. Casey, LIMITED as to definition of medical emergency, informed consent, parental consent, reporting requirements, spousal notice, etc. This case is consolidated with S.C. No. 91-744, Planned Parenthood of Southeastern Pennsylvania et al., filed. (bj)

Feb

148 " 03 Letter dated January 31, 1992 from the U.S. Supreme Court requesting that the record be certified and transmitted to them, received. (bj)

149 " 06 WITHDRAW OF APPEARANCE: Thomas E. Zemaitis for Allentown

Women's Center, for Women's Suburban Clinic, for Women's Health Services, Inc., for Reproductive Health Services & for Planned Parenthood of Southeastern PA, withdrawing appearance. (ghb)

150 " 06 APPEARANCE from Attorneys Linda J. Wharton & Andrew R. Rogoff on behalf of Appellees, filed.

151 " 10 Certified copy of briefs, appendices and partial proceedings in this Court sent to Clerk of Supreme Court of the United States. (anh)

EXCERPTS FROM TRANSCRIPT OF HEARING ON PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER, APRIL 21, 1988

* * *

[13] THE COURT: Mr. Neuhauser, is the Pennsylvania Court system totally unprepared to proceed as required by the amended act?

MR. NEUHAUSER: I can't answer that, your Honor.

[14] THE COURT: I assume you have read the affidavits which are attached to the motion for a temporary restraining order?

MR. NEUHAUSER: I have, your Honor.

THE COURT: As well as the two presented today?

MR. NEUHAUSER: That's right.

THE COURT: They would seem to tell us that the Pennsylvania Court system simply is totally unprepared, that many courts are unaware of the situation and that on a county-to-county basis there has been simply nothing done to implement and execute the provisions of the amended act, as required by my earlier opinions and by the Court of Appeals as pointed out by Mr. Zemaitis.

MR. NEUHAUSER: Well, assuming for the moment the admissibility of the hearsay statements in those affidavits, I would argue nevertheless, your Honor, that as the case law firmly establishes from this Court and other courts that all the Commonwealth has to do is to establish an alternative procedure to parental consent that's prompt, clear, simple and assures confidentiality.

Now, as Mr. Zemaitis has himself conceded, the statute is self-executing. We would submit to the Court that that self-executing statute passes the Constitutional test set by this Court and the Third Circuit in its

previous decisions. I think that Mr. Zemaitis' argument amounts to a [15] statement that the President Judges of the various Courts of Common Pleas either cannot or will not implement a statute that goes into effect, and I don't think that's a proper assumption to make.

The Supreme Court many times has said that state courts are equally capable of enforcing the law and there is no evidence in the cases to suggest that they would not properly implement a statute.

THE COURT: Well, the act goes into effect on Sunday. The language, as cited by Mr. Zemaitis, which is the Third Circuit opinion and which I cite in my opinion last year refers to the fact that the judicial procedure must be an established and practical avenue and may not rely solely on generally stated principles of availability, confidentiality and form.

In other words, the key words, of course, would be established and practical avenue. Now --

MR. NEUHAUSER: And I would submit -- I'm sorry.

THE COURT: -- do we have that here?

MR. NEUHAUSER: I would submit, your Honor --

THE COURT: At this time.

MR. NEUHAUSER: That the statute on its face satisfies that test. It's very explicit, it has very explicit rules contained in it that all proceedings are confidential, the Court must rule within three business [16] days. The record is sealed, the name of the applicant is not on the docket at any place. All persons are excluded from hearings except the applicant and those persons that the applicant wishes to attend. There is an expedited, confidential appeal within five days of either the Court of Common Pleas failure to rule or the Court of Common Pleas denial of the application and that would satisfy the test, in our view, of a clear, concise and simple means to effectuate the judicial bypass procedure.

THE COURT: But at this time if there is a total unawareness, if there is a total unawareness of the provisions in the act and the entire Pennsylvania Court system, by Sunday how can the court system possibly gear itself up to do what is required by the act, the amended act?

MR. NEUHAUSER: Well, your Honor, again, I would indicate that assuming for the purposes of this proceeding that those hearsay statements are admissible, all that amounts to in our view is that there's an argument that the Judges of the Courts of Common Pleas will not see that the law is implemented and I don't think that's a proper presumption to make.

THE COURT: Well, I think you have to come up with some evidence. You've had these affidavits for a few days, I suppose?

[17] MR. NEUHAUSER: No, your Honor, we've had them since yesterday afternoon.

THE COURT: Since yesterday. Well, you've had since yesterday to put yourself together on this. I am reluctant to intrude in this area as a Federal Judge intruding into the State Court system; I'm really reluctant to do it.

MR. NEUHAUSER: I understand, your Honor.

THE COURT: And it seems to me the ideal thing to do would be to have some agreement to maintain the status quo until we can go into this carefully in a preliminary injunction hearing. And I think Mr. Zemaitis suggests and I think there is some merit to what he suggests is that the affidavits do shift the burden to the Commonwealth. In other words, you have these affidavits, they should be accepted on their face. There is no reason to believe that they're not accurate and correct. Considering that, then, the Commonwealth has to come up with something and you've come up with nothing. I'm not criticizing you for it, you've had no

time. But it seems to me it's something you have to look into immediately and, ideally, an agreement to maintain the status quo would give you time to do that.

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EXCERPTS FROM TRANSCRIPT OF HEARING ON PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION, MAY 9, 1988

• • •

[10] BY MR. ZEMAITIS:

Q What is there about Section 3206(A) that prompts you to believe you're required to have the parent make a visit to the clinic?

[11] A I'd like to quote from the law that's in front of me, it just is a line. "He first obtains the informed consent both of the pregnant woman and of one of her parents" and it's the use of the term "informed consent."

Q What is it about the use of that term?

A I've been in health care administration for -- since -- in and out since 1970 and know that there's certain expectations of informed consent that are different from consent and it requires the parents to come in to receive informed consent.

Q If you were told that the parent need not come to the clinic in order to receive informed consent, are there any other reasons why you would nevertheless require parents to come to the clinic?

A Yes. We would still require the parents to come in for identification purposes.

Q Any other reasons that would suggest to you that you require the parent to attend?

A Well, the parents would need to come in for identification and for informed consent because the penalties are severe that are associated with this law, the violation of informed consent rule.

Q When you say the penalties are several, what do you mean by that?

A I consider a three-month revocation of our physician's [12] license to practice medicine a severe penalty, especially for physicians who practice within our

clinic. But the decisions as to what patients we serve are not their own.
Q Are there any other reasons that you believe that the parent would be required to come into the clinic?
A They -- to protect the clinic as well.
Q What do you mean by that?
A Well, we would not be able to function for six months.
Q What's the basis for that statement?
A Well, within the law, that we would not be able to function, with that, that's the risk, that we could have our permission to function revoked by the Department of Health and that our -- that we could -- this failure to obtain informed consent from the parents could be used as evidence in a civil suit against us as well.
Q Do you have any reason to believe you might be subject to such civil actions?
A Well, Women's Health Services is under scrutiny a great deal of the time. We have women who come in who pretend to be patients when they are not, they're just seeking information. We've been asked questions or tested about every possible aspect of the rules and regulations.
Q Who are these people that pretend to be patients?
A Well, primarily the women who pretend to be patients are either themselves or representing groups that are in [13] opposition to abortion.
Q Are you saying that you've had women prior to now pretend to be patients?
A Oh, sure, that happens on a regular basis that they come in and have a pregnancy test or sometimes they'll come in, not being pregnant, and come in with urine that tests pregnant and they'll get as far as the examining table.

• • •

[14] Q Ms. Roselle, given your experience as director, Executive Director of Women's Health Services, what do you think the impact on minor women who seek abortions at Women's Health Service will be if parents are required to come to the clinic for informed consent?
A Well, we're going to have -- we're going to see delays and those delays are going to mean increased risks to health and increased economic forces, increased economic problems for these minors.
Q Why do you expect there to be delay?
A Well, teenagers having a hard time overcoming denial when they make a decision, when they even recognize the fact that they're pregnant. To -- like now they're going to have to overcome the denial, recognize they're pregnant and approach parents to inform them of the pregnancy and to discuss with them their decision and their desire to have an abortion.
Q Any other reasons why there might be additional delay, in your experience?
A Well, once we have a parent involved then we're going to be experiencing some delays in terms of transportation, [15] logistics, other child care, transportation and additional expense relating to that whole logistical issue.
Q You said also that there would be increased risks to minor women, increased health risks. What's your basis for that statement?
A The health risk is associated with the need for more second trimester procedures. There are -- the longer they delay, the more likelihood they're going to be pushed into that category.
Q You also mentioned increased expense to minor women. What's the basis for that statement?
A Well, the increased expenses, the increased logistics and then the increased costs, the increased fee associated with a second trimester procedure.

* * *

[18] Q Have you determined whether the reporting requirements in the new statute will have any financial impact on Women's Health Services?
A At this point I know that I will have to hire one full-time clerical staff person with salaries and benefits. That will cost about $14,000 and then we'll have to hire -- buy some additional office equipment at a cost of another 5,000.
Q Why do you believe you'll need to add a clerical person to your staff?
A I simply don't have -- I'm not staffed at the level to report on -- at this detail on every procedure we do. We don't do that kind of staffing, we don't have extra people. And we have to have it accurate. It just must be [19] accurate. The penalty is too severe.
Q Directing your attention to the form which is Exhibit V?
A Mm-hmm.
Q And specifically to Item 18 of that form which states "Referring physician, agency or service," do you see that?
A Yes.
THE COURT: What exhibit is this?
MR. ZEMAITIS: This is Exhibit V, your Honor.
THE COURT: V.
MR. ZEMAITIS: V as in victor.
THE COURT: Thank you.
MR. ZEMAITIS: And it's Item 18.
THE COURT: Thank you.
BY MR. ZEMAITIS:
Q That item, do you believe that item will have any impact on referring physicians that are currently referring patients to Women's Health Services?
MR. NEUHAUSER: Your Honor, I'm going to object at this point as to what effect it would have on

referring physicians. I think the witness could be competent to testify as to what effect it would have on the clinic, but not on referring physicians.
THE COURT: Overruled. Can this be rephrased?
MR. ZEMAITIS: Yes, your Honor.
BY MR. ZEMAITIS:
[20] Q What do you anticipate the impact on the referral of patients to Women's Health Services will be as a result of requiring the recording of the name of the referring physician, agents to your service?
MR. NEUHAUSER: For the record, your Honor, the same objection.
THE COURT: Overruled.
THE WITNESS: Could you repeat the question, Mr. Zemaitis, please? I'm sorry.
MR. ZEMAITIS: That's all right.
BY MR. ZEMAITIS:
Q What impact do you think the requiring of the naming of the referring physician, service or agency will have on the referral of patients to Women's Health Services?
A Thank you. The naming of the referring physician will guarantee that fewer physicians will refer women to abortion clinics.
Q What's the basis for that statement, Ms. Roselle?
A Referring physicians, especially in areas outside urban areas, are under intense pressure from certain elements, from people opposed to abortion who reside in their community not to make referrals for abortions. And once this becomes known that these physicians are making these referrals they face loss of practice, loss of referral, referrals within their practice, to some extent they may even lose their privileges [21] at a hospital.
MR. NEUHAUSER: Your Honor, for the record I'd like a continuing objection to this testimony.
THE COURT: Yes, you may do that.

Shall we move along?
BY MR. ZEMAITIS:
Q Do you have any personal experience that supports the statement you just made?
A Yes, I do. I approached a group of physicians from a rural area who I know currently make referrals to Women's Health Services. I was hoping I could get them here today or at least to participate in this. Not only would they not do that, they told me that once we had to start reporting this information, they absolutely would never make another referral to us.
Q Did you explain to those gentlemen that the form as filed with the Commonwealth would be maintained in confidence?
A Yes.
Q Did that change their reaction in any way?
A No.

• • •

[27] Q Can you briefly describe the process at Allentown Women's Center for counseling abortion patients?
A The counselor's function is to ensure that the decision to have an abortion is the patient's own decision, that she is not coerced by either a parent or a husband or boyfriend, to explain the medical risks, to assuage fear, to teach birth control, to prepare the patient for the procedure.
Q Is this counseling customarily provided on the day the abortion is performed?
A That's correct.

• • •

[30] Q What is your understanding of the meaning of the term "informed consent," as it applies to Allentown

Women's Center's responsibilities under this act?
A The informed consent for a medical procedure implies a careful explanation of the risks of the procedure and in some cases in the options to the procedure by the physician or his appointee for someone who is anticipating surgery, or in this case whose child is anticipating surgery.
Q Does Allentown Women's Center currently require parents to come to the clinic to provide consent for abortions for their minor children?
A No, we have not and do not.
Q Is it your understanding that under Section 3206(A) that the parent will need to attend to provide consent?
A Informed consent for any medical procedure implies presence.
Q Do you then intend to change your practice of not requiring parental accompaniment should the act go into effect?
A If the act goes into effect we will require parental [31] accompaniment to the clinic when the patient comes for her procedure. In difficult situations of which I anticipate there will be many, a visit at a separate time to the clinic with the minor would be possible, but parental presence at the clinic would be required absolutely.

• • •

[35] Q What effect, if any, do you anticipate that the requirement of informed parental consent, in other words as you've testified, the accompaniment by a parent to provide consent will have on the ability of your minor patients to obtain abortions at the center?
A If the parent needs to come physically to the clinic, that is burdensome. The rigors of just struggling with a service that must be kept confidential, sometimes even from another parent, are hard to imagine. There is a

great deal of intensity around keeping privacy and there's a great deal of intensity around conflict within a family at a crisis moment like this.

Most of our patients come, more than half of our patients come a great distance to get to us; they travel more than an hour. So working out all of those logistics for two people that must both be given, it has to be one parent and the minor instead of a support person to come with the minor will cause additional delays, delays beyond the delays already caused by requiring parental involvement or bypass. Those delays will be great, these delays will be additional.

Q Do you foresee an impact on the emotional state of some of your minor patients through this requirement?

A Yes.

MR. NEUHAUSER: Objection, your Honor, speculation.

THE COURT: Can the question be rephrased?

[36] BY MS. NICHOLAS:

Q In your experience as a counselor are you able to predict an impact on the emotional state of minor patients through this provision?

MR. NEUHAUSER: I'm sorry, your Honor, same objection.

THE COURT: Overruled.

THE WITNESS: In my experience as a counselor I can speak to the 54 percent of our minors who do have parental consent and have sought that voluntarily. Even in that situation, the anguish in a family and the intensity in a family around an abortion service is considerable and when there is dysfunction or hostility in the family unit and the parent is physically present, it is sometimes physically dangerous for the minor. It certainly causes us great concern when there is intensity and upset that they will have an automobile accident as they leave the clinic. These are extremely human, extremely intense and

difficult situations even without the Commonwealth coercing communication in families where there is not support from the parents.

BY MS. NICHOLAS:

Q You've testified about your view that delay will be occasioned in at least some cases by this requirement. Will there be harmful medical effects for minor patients that would result from the delay you've described?

[37] MR. NEUHAUSER: Objection, your Honor, speculation and no foundation.

THE COURT: Overruled. I'm sure you can rephrase that to overcome the objection.

BY MS. NICHOLAS:

Q In your experience as Director and as counselor at Allentown Women's Center is it your view that delay in obtaining abortion can result in adverse medical consequences for patients?

MR. NEUHAUSER: Same objection, your Honor.

THE COURT: Overruled.

THE WITNESS: Delay is grave. Delay after the twelfth week of gestation increases the possibility of a medical complication from the abortion at a very steep incline. There are other problems that don't show up immediately that are caused by delay. The cervix needs to be dilated mechanically for an abortion. We don't really know each week that goes by how much worse it is in terms of impairment of future childbearing ability, but certainly for young women future childbearing ability is extremely important. And as those weeks go by it's worse and worse on many levels. It's also very serious in terms of the expense and the psychological impact on that young woman if she has a later abortion. Each week that goes by is a difference in degree. But many of these minors who are required to either [38] cope with the court system which is a frightening and overwhelming prospect or with their parents which is a frightening and

overwhelming prospect for many of them will delay right past the second trimester abortion situation and have a child as a child for the sole reason that they can't cope with the burdens of these requirements. That's, I think, you know, very sobering.

BY MS. NICHOLAS:

Q I'd like to turn briefly to the reporting sections of the act and in particular direct your attention to Section 3214(A) which requires filing a report to the Department of Health for each abortion performed. Are you familiar with this section?

A Yes.

Q And I would like to further direction your attention to Subsection 1 which requires identification in the individual abortion report of the physician performing the abortion and of the referring physician, service or agency. Are you familiar with this section?

A I'm extremely familiar with this.

Q What effect do you believe this reporting subsection will have on the operations of Allentown Women's Center?

MR. NEUHAUSER: Objection, your Honor, speculation.

THE COURT: Overruled.

THE WITNESS: I was devastated when I read this. [39] I think that this is going to make it more difficult for us to recruit the kinds of physicians we want working for us providing abortion services. I have already been told by a physician who formerly worked for us that whether or not this law goes into effect, whether or not these reports are made public, he would never darken our door again because of his fear of the possibility of harassment that might ensue from these reporting requirements.

It will have a chilling effect on the number of physicians and the quality of physicians willing to provide

abortion services.

* * *

[42] BY MR. ZEMAITIS:

Q Dr. Dratman, let me just confirm for the record that you are a licensed physician?

A Yes, I am.

Q In what states are you licensed?

A I'm licensed in Pennsylvania and New Jersey.

Q And where did you receive your medical degree?

A From Hahnemann Medical College in Philadelphia.

Q Are you a member of any professional organizations?

A Yes, I am.

Q And what are those?

A I am a member of the American College of Obstetrics and Gynecology, I am a Fellow of that college. I am a member of the American Fertility Society and the American Medical [43] Women's Association.

Q Have you received any certification in a specialty?

A Yes, I have. I am Board Certified in the practice of obstetrics and gynecology.

Q What is your current position, Dr. Dratman?

A Since 1986 I have been the Medical Director for Planned Parenthood, Southeastern Pennsylvania.

Q What are your responsibilities as Medical Director of Planned Parenthood?

A As Medical Director I oversee medical policy for our contraceptive and abortion services. I assist in the training of physicians in the abortion service and of mid-level practitioners in the contraceptive service.

* * *

[45] Q Dr. Dratman, do you have an opinion as to the

first point in a pregnancy that a fetus is likely to be viable?
A Yes, I do.
Q And what is your opinion in that respect?
A A fetus is -- it's impossible for a fetus to be viable, that is to sustain extrauterine life, even with the best available technological supports, before 23 to 24 menstrual weeks gestation.
Q What is the basis for your opinion in that respect?
A A fetus needs lung matrix in order to breathe on the outside, whether mechanically ventilated or not, and alveoli do not develop in the human fetus until 23 to 24 weeks gestation.
Q Are you aware of any literature that contradicts your opinion with respect to 23 or 24 weeks?
A There have been sporadic reports in the medical literature of survivals of fetae of 22 weeks gestation. But most of those reported before the use of ultrasound for data and it's possible that the data may have been off by a week or so.
Q Are you aware of medical literature that supports your conclusion with respect to 23 or 24 weeks?
A Yes. There are considerable numbers, both in the obstetrical and the neonatology literature. It's also possible to find descriptions of fetal womb development in [46] pathology textbooks.
Q In your opinion, Dr. Dratman, is there any possibility that a 19 or 20 or 21 week old fetus would be viable?
A Not if properly dated, no.
Q Is that also true for a 22 week old fetus?
A Yes.

• • •

[57] Q Now, directing your attention to Item 17 on the form Report of Induced Termination of Pregnancy, there

are a series of questions that are asked in that item and the direction is to explain the answers on the back. Are you aware of any other procedure, Dr. Dratman, where a physician is required to report his or her basis for certain medical judgments made during the treatment of a patient?
[58] A No, sir, I am not.
Q What is your reaction, as a practicing physician, to a requirement that you report the basis for certain medical judgments on this form?
A I find them confusing at best, intrusive at worst. In the face of a medical emergency which is not very well defined in this act, although an attempt is made at it, the difficulties that a physician and his or her patient face must take precedence over anything else. Were the statute to be upheld, the statute itself would get in the way of these treatments. The way the statute is written, and that is Section ...
Q Are you referring to the definition of medical emergency, Dr. Dratman?
A Yes, I am.
Q That's Section 3203, if you'll find that section.
A Okay. Yes, here it is. On the face of it --
Q Before you comment on the medical emergency section, the question I had asked you was whether you had any reaction to all of Item 17, that is to say all of the requests by the reporting form to report your basis for a medical judgment?
MR. NEUHAUSER: Asked and answered, your Honor, I believe.
THE COURT: Overruled.
THE WITNESS: I find that this has nothing to do [59] with medical practice and it's causing me to make artificial judgments and therefore reports.
BY MR. ZEMAITIS:
Q Specifically referring to the definition of medical

emergency and you now have that before you, I believe, don't you?

A Yes.

MR. ZEMAITIS: That's Section 3203, your Honor.

BY MR. ZEMAITIS:

Q Do you have an opinion as to whether that section would or may cause physicians to practice in emergency situations different than they otherwise would?

A Oh, absolutely.

Q It would, that's your opinion is that it would have that effect?

A Certainly.

Q Now, can you explain the basis for your opinion in that respect?

A Let me give you an example. There is in the body of this statute the requirement for parental consent or judicial bypass, including some reasonable time in which such judgments can be made. I think three days is in the statute. Let's say a 16 year old woman comes into the emergency room, she is pregnant, she's about 18 weeks pregnant, she is swollen, her blood pressure is 210 over 160, normal being [60] between 100 and 120 over 60 to 80 in that age range, and her urinalysis shows a considerable amount of protein in the urine and her reflexes are very brisk. This is a clinical syndrome known as preeclampsia or toxemia of pregnancy. This is in obstetrical terms a medical emergency. However, under this statute, before I could operate as if this were a medical emergency, I would have to prove that irreversible major bodily harm would come to this patient if I were not to wait for a judicial bypass to go through.

Now, preeclampsia is a very serious condition. It can lead to eclampsia, which means that the woman would have a seizure. However, most of these women don't die as a result of the seizure, they don't have any long-term

effects from it, but she could certainly be terribly ill, she could certainly sustain a concussion or other injury from the seizure. She could develop a condition known as DIC, disseminated intravascular coagulation in which all of the blood clotting products in her body are used up; this is part of the syndrome. And what the statute is asking me to do in effect is to guarantee that this woman is going to be okay for the up to three days it's going to take to get judicial bypass for me to abort here because the only treatment that there is for this condition is emptying the uterus and ending the pregnancy. And there are medications that can be used in an attempt to stabilize her, drugs to bring down her blood [61] pressure, magnesium sulfate to attempt to keep her from having a seizure, but those are only temporizing medications in this situation.

I can't guarantee that she's going to have any lasting or non-lasting effects from this. She may have an underlying kidney problem that caused her to become so severely ill at this point in the pregnancy, but I can't diagnose that until afterwards. So there is no way that I, using my good medical judgment and with concern for the safety of my patient, can comply with this.

* * *

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, et al.	:	**CIVIL ACTION NO. 88-3228**
v.	:	
ROBERT P. CASEY, et al.	:	

ORDER

AND NOW, this 25th day of October, 1988, upon consideration of plaintiffs' request for class certification and of the Stipulation of the parties with respect thereto, the Court hereby finds as follows:

1. The class of physician plaintiffs is so numerous that the joinder of all members is impracticable. At the end of 1986, there were at least 1,578 gynecologists practicing in Pennsylvania, and there were at least 144 facilities in Pennsylvania where abortions are performed, each of which has one or more physicians on its staff.

2. There are questions of law and fact common to the class of physician plaintiffs including the constitutionality of provisions of 1988 Amendments to the 1982 Pennsylvania Abortion Control Act, Act of March 25, 1988, No. 31, §§ 3-10, amending 18 Pa. C.S.A. §§ 3201-20 (the "Act").

3. The claims of plaintiff Thomas Allen, M.D. as the representative of the class of physician plaintiffs are typical of those of the class as a whole.

4. Plaintiff Thomas Allen, M.D. will fairly and

adequately represent the interests of the class of physician plaintiffs because he possesses the requisite personal interest in the subject matter of the lawsuit and because he is represented by lawyers with substantial experience in civil rights and class action litigation, particularly cases involving the reproductive rights of women seeking abortion and the rights of physicians to provide such care.

5. Plaintiff Thomas Allen, M.D. possesses no known interests that are antagonistic to those of the class of physician plaintiffs.

6. The defendants have acted on grounds generally applicable to the class of physician plaintiffs.

7. The prosecution of separate actions by the individual members of the class of physician plaintiffs would create a risk of inconsistent or varying adjudications with respect to the constitutionality of the Act or the particular provisions thereof that could establish incompatible standards of conduct for the defendants who are charged with enforcing the Act's provisions.

WHEREFORE, it is hereby ORDERED and DECREED that this action will be maintained as a class action pursuant to Rules 23(B)(1)(A) and 23(B)(2) of the Federal Rules of Civil Procedure on behalf of a class of physician plaintiffs defined as follows: "All licensed physicians in Pennsylvania who provide abortions at locations in Pennsylvania." Plaintiff Thomas Allen, M.D. is designated class representative, and counsel of record for plaintiffs in this action are designated as counsel for the class.

BY THE COURT:

/s/_____
DANIEL H. HUYETT, 3rd

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA; REPRODUCTIVE HEALTH AND COUNSELING CENTER; WOMEN'S HEALTH SERVICES, INC.; WOMEN'S SUBURBAN CLINIC; ALLENTOWN WOMEN'S CENTER; AND THOMAS ALLEN, M.D., on behalf of himself and all others similarly situated;	:	**CIVIL ACTION**
Plaintiffs,	:	
v.	:	**CLASS ACTION**
ROBERT P. CASEY, N. MARK RICHARDS, ERNEST PREATE, personally and in their official capacities, and MICHAEL D. MARINO, personally and in his official capacity, together with all others similarly situated,	:	**NO. 88-3228**
Defendants.	:	

AMENDED COMPLAINT

Plaintiffs, by their undersigned attorneys, bring this Amended Complaint against the defendants, their employees, agents and successors and in support thereof aver the following:

I. *Preliminary Statement*

1. This civil rights action challenges the 1988 and the 1989 amendments to the Pennsylvania Abortion Control Act of 1982, Act of March 25, 1988, No. 31 §§ 3-10, amending 18 Pa. Cons. Stat. Ann. §§ 3201-20, and Act of November 17, 1989, No. 64, amending 18 Pa. Cons. Stat. Ann. §§ 3201-20, (collectively "the Act") as violating the United States Constitution, 42 U.S.C. § 1983 and the Pennsylvania Constitution. (Copies of each amending enactment are attached as Exhibits "A" and "B," respectively.)

2. Plaintiffs seek declaratory and injunctive relief on the ground that the Act unduly restricts the availability of abortions and women's access to necessary medical care and counseling, as well as the rights of physicians and facilities providing abortions in violation of the right of privacy to make personal decisions, the right of informational privacy, the right to free speech, the right to equal protection under the law, the right to equality of rights under the law, the right to due process of law, and the right to freedom of association, all as guaranteed by the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the United States Constitution, 42 U.S.C. § 1983, and Article I §§ 1, 26 and 28 of the Pennsylvania Constitution.

II. *Jurisdiction*

3. Jurisdiction is conferred on the Court by 28

U.S.C. §§ 1331, 1343(a)(3), 1343(a)(4), the Fourteenth Amendment to the United States Constitution, and, because plaintiffs' state law claims are inextricably tied to plaintiffs' federal claims, the doctrine of pendant jurisdiction.

4. Plaintiffs' claim for declaratory and injunctive relief is authorized by 28 U.S.C. §§ 2201 and 2202 and by Rules 57 and 65 of the Federal Rules of Civil Procedure.

III. *Parties*

A. *Plaintiffs*

5. Plaintiff Planned Parenthood of Southeastern Pennsylvania is a non-profit corporation organized under the laws of the Commonwealth of Pennsylvania that operates a facility where abortion counseling services and abortions are provided at a location in Pennsylvania.

6. Plaintiff Women's Suburban Clinic is a non-profit corporation organized under the laws of the Commonwealth of Pennsylvania that operates a facility where abortion counseling services and abortions are provided at a location in Pennsylvania.

7. Plaintiff Reproductive Health and Counseling Center is a for-profit corporation organized under the laws of the Commonwealth of Pennsylvania that operates a facility where abortion counseling services and abortions are provided at a location in Pennsylvania.

8. Plaintiff Women's Health Services, Inc. is a non-profit corporation organized under the laws of the Commonwealth of Pennsylvania that operates a facility where abortion counseling services and abortions are provided at a location in Pennsylvania.

9. Plaintiff Allentown Women's Center is a for-profit corporation organized under the laws of Pennsylvania that operates a facility where abortion counseling services and abortions are provided at a

location in Pennsylvania.

10. Each of the corporate plaintiffs (hereinafter collectively referred to as "medical providers") sues on its own behalf, on behalf of the physicians, counselors and staff that each employs at its facility, and on behalf of the women who receive abortions and other obstetrical, gynecological, family planning, or counseling services at its facility.

11. Plaintiff Thomas Allen is a physician licensed to practice medicine in Pennsylvania who specializes in the practice of obstetrics and gynecology. Dr. Allen performs abortions during the first and second trimesters of pregnancy at locations in Pennsylvania.

12. Plaintiff Allen sues on his own behalf and on behalf of his patients and seeks to represent a class of all other physicians similarly situated.

B. *Defendants*

13. Defendant Robert P. Casey is the Governor of the Commonwealth of Pennsylvania. He is the chief executive officer of the Commonwealth, and he is constitutionally mandated to ensure that the laws of the Commonwealth, including the Act, are faithfully executed.

14. Defendant N. Mark Richards is the Secretary of Health for the Commonwealth of Pennsylvania. As such, he is responsible for the implementation and enforcement of those provisions of the Act which pertain to the Department of Health.

15. Defendant Ernest Preate is the Attorney General of Pennsylvania. As such, he is responsible for the enforcement of all laws of the Commonwealth, including the Act.

16. Defendant Michael D. Marino is the District Attorney for Montgomery County, Pennsylvania. As such, he is responsible for the enforcement of the Act and the criminal prosecutions of persons charged with

violating it in his county.

17. Upon information and belief, unless restrained by order of the Court, all defendants will perform their official duties to ensure the Act is enforced, and will cause criminal prosecutions or license suspension or revocation hearings to be instituted against the physician or medical provider plaintiffs or others who may aid or assist the physician or medical provider for failure to comply with the Act, and against married women who provide false statements in violation of Section 3209 of the Act.

IV. *Class Action Allegations*

A. *Plaintiff Allegations*

18. Plaintiff Allen is a physician licensed to practice medicine in Pennsylvania who provides abortions at locations in Pennsylvania.

19. Dr. Allen sues on behalf of all other physicians similarly situated and seeks, pursuant to Fed. R. Civ. P. 23(b)(1)(A) and (2), to represent a class composed of all licensed physicians in Pennsylvania who provide abortions at locations in Pennsylvania.

20. The prerequisites to class certification are met in that:

(a) At the end of 1988, there were at least 1,567 gynecologists practicing in Pennsylvania, and there were at least 140 facilities in Pennsylvania where abortions are performed, each of which has one or more physicians on its staff; consequently the class is so numerous that joinder of all members is impracticable;

(b) The provisions of the Act apply with equal force to all members of the class, such that questions of law and of fact relating to the constitutionality of the provisions of the Act

that seek to regulate abortions are common to all members of the class;

(c) The claims of the representative party as to the unconstitutionality of the provisions of the Act are typical of those in the class; and

(d) The representative party has the requisite personal interest in the outcome of this action and will fairly and adequately protect the interests of the class.

21. The prosecution of separate actions by individual members of the class would create a risk of inconsistent or varying adjudications with respect to the constitutionality of the Act or the particular provisions thereof that would establish incompatible standards of conduct for the defendants who are charged with enforcing the Act's provisions.

B. *Defendant Allegations*

22. Defendant Michael D. Marino is sued in his capacity as the District Attorney of Montgomery County, Pennsylvania and, pursuant to Fed. R. Civ. P. 23(b)(1)(A), as the representative of the class of all district attorneys of the various counties of the Commonwealth of Pennsylvania.

23. The prerequisites to certification of a defendant class are met in that:

(a) There are 67 counties in Pennsylvania each of which has a district attorney and many of which have a substantial number of assistant district attorneys rendering the class so numerous that joinder is impracticable;

(b) Because each member of the class is charged with enforcing the Act in a particular county, questions of law and of fact relating to the constitutionality of the Act's provisions are common to the class;

(c) The defenses of defendant Marino will be

typical of the defenses of the class; and

(d) Defendant Marino will fairly and adequately represent the interest of the class.

24. The prosecution of separate actions against individual members of the defendant class could create a risk of inconsistent adjudications with respect to members of the defendant class which would establish incompatible standards of conduct for physicians presently performing abortions, desiring to perform abortions, or referring patients for abortions in Pennsylvania.

V. *Factual Allegations*

25. In 1988, 50,786 abortions were performed in Pennsylvania and reported to the Pennsylvania Department of Health. Many of the women who sought abortions did so because they suffer from diseases or conditions including, but not limited to: diabetes, cancer, essential hypertension, cardiac disease, kidney disease, history of post partum hemorrhaging, or sickle cell anemia and, therefore, carrying a pregnancy to term would endanger their health or life. Others sought abortions because their age, their psychological, familial or financial condition or their religious or conscientious beliefs mandated the procedure or because they were infected with the AIDS virus or because fetal anomalies had been discovered.

26. 47,548 (or 93.6%) of all reported abortions in 1988 in Pennsylvania were performed during the first trimester of pregnancy; 3,122 (or 6.2%) were performed during the second trimester. 127 abortions were performed between 23 and 26 weeks from the woman's last menstrual period and one abortion was performed at 27 weeks or beyond.

27. Abortion at any stage of pregnancy is considered an extremely safe surgical procedure, eleven times safer

from the standpoint of mortality than carrying a pregnancy to full term. Early abortion is safer than later abortion.

28. Delay in performance of abortion increases the health risk that women face in connection with the procedure. Nevertheless, second trimester abortions are safer than carrying the pregnancy to full term.

29. Physicians practicing at clinics operated by the medical provider plaintiffs regularly treat women patients who need abortion services. The physicians either perform the abortions or they refer patients to other physicians or clinics for abortions, and thus are subject to the criminal and civil penalties contained in the Act.

30. Physicians and medical providers who refer patients for abortions normally provide medical services for those patients before and/or after the procedure is performed.

31. Physicians and medical providers desire to provide comprehensive and confidential medical care of the highest quality to their patients.

32. Some or all of the plaintiffs provide abortion services to women including: women who need immediate abortions due to a medical emergency, women who need immediate abortions because of danger to their health but whose health problems do not fall within the definition of "medical emergency" as contained in the Act, women who travel long distances to obtain abortions, women for whom a waiting period of twenty-four hours would greatly increase the cost of and delay in obtaining an abortion, emancipated minors, mature minors, immature minors for whom an abortion would be in their best interest, immature minors for whom consent of one parent would be in their best interest, immature minors for whom parental involvement would not be in their best interest and married women who for varied reasons are unable or

unwilling to notify their husbands of their decision to have an abortion.

33. The purpose, intent and effect of the Act is to impose burdens upon women attempting to obtain abortions in Pennsylvania, to restrict the availability of abortion services, and to exact medical, psychological and financial penalties upon women who seek abortions.

34. The Act is the only provision of law enacted by the Pennsylvania General Assembly that provides detailed regulation of a particular surgical procedure. This regulation embodies legislative determinations that are inconsistent with currently accepted medical practice, and that require physicians to violate medical, ethical and professional standards.

35. If the Act is permitted to take effect, the cumulative impact of its provisions will be to burden unduly the constitutionally protected rights of plaintiffs and their patients with respect to the abortion decision, as more fully described in paragraphs 36 through 104 of this Amended Complaint.

A. *Definition of "medical emergency" (Section 3203).*

36. Section 3203 defines the term "medical emergency" in a way that does not make clear to the practicing physician when s/he will risk incurring license suspension or revocation or other liability by terminating a pregnancy because s/he may interpret the definition differently from the prosecuting attorney.

37. The definition of "medical emergency" is unduly narrow and, as such, does not comport with either generally accepted medical definitions and usage or with Pennsylvania statutory and common law definitions of the term.

38. The Act's definition of "medical emergency" may cause the physician to practice medicine in a manner contrary to the physician's best medical judgment in instances where a delay in the abortion procedure will

have significant adverse effect on a woman's health but where an immediate abortion is not necessary to avert the death of the woman or to prevent substantial and irreversible loss of a major bodily function.

39. The Act's definition of "medical emergency" may cause the physician to refuse to perform an abortion when, in the exercise of judgment and in the absence of the provision, s/he would do so, thereby interfering with the patient's ability to obtain an abortion.

B. *Informed Consent (Sections 3205 and 3208).*

40. Except in a "medical emergency" as defined in Section 3203, Section 3205 requires that a doctor wait twenty-four hours between the time a woman is supplied information which the Act declares to be necessary for informed consent and the performance of the abortion, under penalty of license suspension or revocation or criminal liability.

41. Of 67 counties of Pennsylvania, 10 have no practicing obstetricians/gynecologists. In 22 counties, 5 or fewer obstetricians/gynecologists practice and in many of these locations no physicians perform abortions. 97.8% of all abortions in the state are performed in only 8 counties: Allegheny, Dauphin, York, Lehigh, Philadelphia, Delaware, Chester and Montgomery Counties. Women from every county in the Commonwealth, as well at 2975 women from other states and territories, obtained abortions in Pennsylvania in 1988.

42. Because of the scarcity of providers and a desire for privacy, many women travel long distances at considerable expense to obtain abortions. Many women are forced to travel in excess of 50 miles, or 2 hours travel time, to reach a provider. For women in remote, rural counties of the state, this distance can exceed 100 miles and 4 hours travel time, each way.

43. Because of shortages of medical personnel and

other resources, plaintiff physicians and medical providers do not provide abortion services every day. The twenty-four hour waiting period will therefore create delays in excess of twenty-four hours, endangering women's health. Conflicts with patients' personal schedules will compound these delays.

44. The 24-hour waiting period will require that women make two or more, often long-distance, roundtrips to their physicians or medical providers, thereby increasing their travel and lodging costs, child care expenses, time lost from work for themselves and others wishing to accompany them on the visit and physical and emotional strain.

45. Prior to seeking medical treatment, women who seek abortions have given thought and moral deliberation to the matter and have concluded in accordance with their own life circumstances that an abortion is in their best interest. Therefore, the 24-hour delay mandated by the statute serves no legitimate state interest.

46. In some circumstances, delaying an abortion for twenty-four hours will jeopardize a woman's health but not so severely as to fall within the medical emergency exception, thereby requiring the physician to postpone the abortion procedure contrary to his or her best medical judgment and to the woman's interest in health and personal security.

47. The 24-hour waiting period imposes additional trauma upon women who seek abortions because they are the victims of rape or incest, and upon young women who generally delay seeking medical care longer than adult women and who are subject to other delays as a result of the operation of Section 3206 of the Act.

48. The 24-hour waiting period constitutes a direct and unwarranted interference with the physician-patient relationship in that it prevents the physician and patient

from deciding that an abortion after a delay of less than twenty-four hours is in the patient's best interest.

49. Section 3205(a)(1) requires the attending or referring physician orally to supply certain information to the woman. By prohibiting the delegation of this task to another qualified professional, this requirement interferes with a woman's abortion decision, by increasing costs, constricting medical judgment, and preventing the proper allocation of scarce medical resources, while serving no legitimate interest.

50. Section 3205(a) also requires that specific categories of information, declared to be necessary for "informed consent," be provided to each woman seeking an abortion.

51. Sound medical practice requires that a physician or other provider carefully tailor the information communicated to each patient in the informed consent dialogue. Section 3205 eliminates the exercise of discretion and may cause a physician to provide information contrary to his or her best medical judgment in his or her explanation of the procedure and its attendant risks.

52. Pennsylvania law governing informed consent for surgical procedures other than abortions allows the physician to exercise sound medical discretion in determining the nature and extent of the information provided to the patient consistent with the patient's particular needs.

53. Section 3205(a)(2) requires that the physician or the physician's designated agent supply legal advice concerning the potential availability of medical assistance benefits and liability for child support which is not the physician's, or his or her agent's, area of expertise.

54. Sections 3205(a)(2) and 3208 require that a physician or his or her designated agent inform a woman that she has a right to printed materials that describe the

fetus at two week gestational increments, contain "pictures" of a fetus at two week gestational increments, and list agencies that offer alternatives to abortion.

55. Such a requirement will compel physicians and medical providers to act contrary to their best medical judgment by furnishing information which in some cases will cause substantial psychological harm to their patients.

56. Sections 3205(2) and 3208 severely and unduly interfere with the quality of the physician-patient relationship by calling into question the integrity of the physician and undermining his or her ability or the ability of the physician's agent to counsel the patient on an individualized basis.

57. These sections violate the right of free speech of physicians or their agents by compelling them to furnish information prepared and provided by the Commonwealth, even when contrary to their own religious or conscientious beliefs, or even when provisions of the information may violate professional standards.

C. *Parental Consent/Judicial Bypass (Section 3206).*

58. 11.6% of all women having abortions in Pennsylvania in 1988 were under the age of 18.

59. Except in the case of a "medical emergency" as defined by Section 3203 of the Act, Section 3206 establishes a requirement that one parent give his or her informed consent to an abortion for any minor daughter who is less than 18 years of age and who is not emancipated, unless a court determines that she is mature and capable of making her own decisions or, if immature, that an abortion is in her best interest.

60. This section does not set forth what procedures and documentation are necessary for obtaining legally valid parental informed consent. Physicians and facilities, therefore, will be subject to professional

sanction and criminal liability for acts or omissions a prosecutor or court may later deem proscribed by the Act.

61. Because of its vague and ambiguous language, Section 3206 has the purpose and effect of discouraging physicians and facilities from providing abortions for unemancipated minors, or causing unnecessary and possibly dangerous delay in performing such abortions.

62. Under Section 3205, obtaining the "informed consent" of a woman seeking an abortion requires that the performing or referring physician, a qualified physician assistant, health care practitioner, or a technician to whom the responsibility has been delegated, orally convey information regarding the procedure, the risks and alternatives to the procedure and other information a reasonable patient would consider material to the abortion decision. Additionally, section 3205 provides that the woman certify in writing prior to the abortion that she has been provided such information.

63. Because the provisions of Section 3205 regarding "informed consent" also apply to Section 3206's provision for parental informed consent, physicians and facilities will be required to comply fully with Section 3205's provisions, including the requirements of separate personal counseling with, and certified proof of, a parent's consent to an abortion for a minor daughter.

64. Particularly where a parent is prepared to consent but, because of work schedules, illness or other circumstances finds it difficult to receive personal counseling, Section 3206 is unduly burdensome and is likely to cause dangerous and expensive delay in the abortion procedure and dramatically to increase the cost of obtaining the medical service.

65. Some parents, although willing to consent to an abortion for their minor daughter, are not willing to

accompany her to the medical provider nor to provide assistance to her which creates an appearance that the parent supports the daughter's choice.

66. The operation of the informed consent provision in Section 3206 will interfere with family integrity in that it will force previously unwilling parents to consent and to papticipate in the minor's abortion decision.

67. Section 3206(f), sets forth the procedure by which an unemancipated minor may obtain judicial authorization for an abortion in the absence of parental consent ("the judicial bypass"). It provides that a minor woman may apply to the Court of Common Pleas for a determination of whether she is mature and capable of giving informed consent or, if she is immature and incapable of consent, whether having an abortion would be in her best interests.

68. This section, if implemented, will cause dangerous delays and will increase the risk of invasions of privacy of pregnant minors choosing the judicial bypass procedure. Neither the trial courts nor the appellate courts of the Commonwealth are prepared to effectuate this procedure and to assure expedition and confidentiality. No implementing rules have been issued by the Supreme Court of Pennsylvania. The common pleas courts of many counties are now straining under the burden of overloaded dockets and a shortage of judges and court personnel. Under these circumstances, pregnant minors availing themselves of the judicial bypass procedure cannot be assured that their rights to confidentiality and expedited consideration will be preserved. It is the Commonwealth's burden to demonstrate that its courts are prepared to implement this section to assure that the rights of minor women seeking abortions are protected.

D. *Husband Notification (Section 3209).*

69. Except in the case of a "medical emergency" as defined by Section 3203 of the Act, Section 3209 prohibits a physician from performing an abortion upon a woman if that woman has not provided him or her with a signed statement that she has notified her spouse that she intends to have the procedure performed, with the exceptions that no such statement is required if the spouse is not the father of the fetus, the spouse "after diligent effort" could not be found, the pregnancy is the result of spousal sexual abuse, or the woman has reason to believe that notifying the spouse is "likely" to result "in the infliction of bodily harm upon her by her spouse or by another." While the statement need not be notarized, it must "bear a notice that any false statements made therein are punishable by law." The woman making a false statement is thus subject to the criminal penalties of a misdemeanor of the third degree. The physician is subject to license suspension or revocation and civil or criminal penalties for violation of this provision.

70. This provision purports to further "the Commonwealth's interest in promoting the integrity of the marital relationship and to protect a spouse's interest in having children within the marriage and in protecting the prenatal life of that spouse's child . . . ."

71. None of these "interests" are sufficiently compelling to warrant a burden on the woman's right to an abortion. Further, this provision is not narrowly tailored to further the purported "interests" and is an unjustifiable governmental intrusion into the privacy of the marital relationship.

72. The vast majority of married woman consult with their husbands when deciding whether to terminate a pregnancy that is the product of that marriage. When they do not, it is for legitimate reasons many of which are not covered by the statutory exceptions including:

dysfunctional marital relationships, separations, the woman's fear of violence against her children, fear that her husband will physically prevent her from having an abortion or cut off financial support for her and her children and/or religious or ethical differences between spouse. In a healthy marital relationship, reproductive decisions can and will be made without the intrusion of the Commonwealth, and such intrusion is likely to damage the integrity of the marital relationship.

73. No third party, including the spouse, has an interest the Commonwealth may further as against the woman's right to decide to have an abortion.

74. The requirement of Section 3209 that a woman notify her husband is likely to cause delay in the scheduling of a woman's abortion when her husband may be unavailable for notification at the time she needs to have the abortion performed. If the spouse is living apart from the woman, she will be required to delay the medical procedure for additional time while she makes a diligent effort to locate him.

75. In some circumstances, the delay caused by the operation of Section 3209 will jeopardize a woman's health, but not so severely as to fall within the definition of "medical emergency" as defined by Section 3203 of the Act, thereby causing, the physician to postpone the abortion in violation of his ethical and professional standards.

76. Section 3209 allows an exception where the spouse cannot be located but only after "diligent effort" has been made to find him. The term "diligent effort" is undefined thus subjecting the woman who invokes the exception in a certified statement to her physician to criminal sanction for violating a vague and ambiguous provision.

77. Section 3209 provides for an exception where the woman "has reason to believe that the furnishing of

notice to her spouse is likely to result in the infliction of bodily harm upon her by her spouse or another individual."

78. This provision does not specify what factors the woman is authorized to consider in determining whether bodily harm is "likely." The provision therefore threatens women who invoke this exception by certified statement to their physicians with criminal sanction without providing any guidance as to what constitutes a reasonable belief she is likely to be harmed as a result of compliance with the spousal notice requirement.

79. Women who have been harmed are not always able to determine when and for what reason they will be harmed again. A woman who may not think it is "likely" that she will be physically harmed, may nonetheless choose not to subject herself to the risk.

80. A woman seeking an abortion is not necessarily in the best position to know all of the psychological factors that might trigger bodily harm to her. Section 3209 is an unjustifiable burden on the woman's right to have an abortion, an intrusion into the physician-patient relationship and into the marital relationship, and fails to further the asserted Commonwealth interests.

81. Section 3209 provides no exception for and, accordingly, no protection against non-physical coercion by husbands. Even if a husband opposed to a woman's attitudes regarding an abortion has threatened to publicize her choice, to retaliate economically, to retaliate in future child custody proceedings, or has threatened psychological intimidation or harm, the Commonwealth provides no exception to the husband notification requirement. In many circumstances, therefore, Section 3209 grants husbands an effective means of intimidation to burden unduly women's reproductive choices.

82. The fact that a woman is pregnant, the fact that

she is considering an abortion, and the fact that she has chosen to obtain an abortion are personal matters of the most intimate, sensitive and private nature. Such facts are protected by longstanding and powerful expectations of confidentiality. By forcing women to disclose those facts, Section 3209 offers no protection against arbitrary, irresponsible or malicious dissemination by husbands of personal information which their wives have been forced by the Commonwealth to disclose to them.

83. A variety of medical and surgical interventions, including, but not limited to, vasectomies, prostate operations and chemotherapy can affect the capacity of males to have children within marriage.

84. The Commonwealth places no limits on the ability of a husband to make choices that will or may affect his own reproductive capacity without notifying his wife.

85. The Commonwealth of Pennsylvania's husband notification requirement is based on an invidious, outmoded and stereotypical conception of women's roles within marriage as being responsible to their husbands for their reproductive status and choices.

86. Imposing a spousal notice requirement upon women's reproductive choices, but not upon men's abridges women's right to equality under the law and denies women equal protection of the law.

E. *Determination of Gestational Age (Section 3210).*

87. Except in the case of a medical emergency as defined by Section 3203 of the Act, Section 3210 requires that physicians performing an abortion must "perform or cause to be performed such medical examinations and tests as a prudent physician would consider necessary to make or perform in making an accurate diagnosis with respect to gestational age."

88. The physician must then make a report as to the tests conducted and the results thereof or be subject to

license suspension or revocation and criminal sanction. This requirement subjects physicians to harsh penalties without specifying the examinations to be performed and is an unjustified intrusion into the physician-patient relationship.

89. Although a physician is able through discussion and physical examination, to date a pregnancy for purposes of choosing an abortion technique, modern technology now enables physicians to determine with extreme accuracy gestational age of the fetus.

90. Rather than requiring the physician to make a determination of the gestational age of the fetus sufficient to perform his medical duties in accordance with ethical and professional standards, Section 3210 will require physicians to perform unnecessary tests, that typically cost $250 to $300, but that may cost far in excess of that amount, solely to comport with the Act's requirement. The use of these tests will not to promote patient health, in violation of the physician's right to due process and privacy rights and in violation of the privacy rights of his patient.

F. *Reporting requirements (Sections 3207 and 3214).*

91. Section 3207(b) requires, under threat of a daily fine of $500, that all facilities in the Commonwealth, including physician's offices, at which abortions are performed, file and update reports disclosing the name and address of the facility, affiliated or subsidiary facilities and other facilities having contemporaneous ownership or directorship. These reports will be open to public inspection if filed by facilities that received any state-appropriated funds for any purpose in the twelve months prior to the filing of the report.

92. Section 3214(f) requires each facility to file quarterly reports showing the total number of abortions performed per trimester of pregnancy, under threat of license suspension or revocation and criminal liability.

These reports will be open to public inspection if filed by facilities that received any state-appropriated funds for any purpose in the twelve months prior to the filing of the report.

93. This conditioning of confidentiality upon receipt of state-appropriated funds is unconstitutional and serves no legitimate Commonwealth interest.

94. It is reasonable to fear violent actions by abortion opponents because, in the Commonwealth and throughout the United States, there have been numerous incidents of violence and harassment directed at abortion providers. These incidents include picketing with intent to block the entrances of abortion facilities and prevent abortions, building takeovers, firebombing, kidnappings, written and telephones threats and malicious cancellation of telephone lines.

95. Disclosure of reports filed by facilities receiving state-appropriated funds has the purpose and effect of penalizing physicians who perform abortions or medical providers by exposing them to violent actions, harassment or interference with business relationships by persons who oppose abortion. Women who seek abortions from these facilities may also be exposed to violent actions or harassment, thereby penalizing them for exercising their constitutional right to choose to have an abortion.

96. This disclosure discourages others from associating with abortion providers for fear that disclosing their affiliation will subject them to an increased risk of violent actions, harassment, or interference with business relationships by persons who oppose abortion.

97. Section 3214(e)(3) requires that reports of individual abortions be made available to public officials for use in their enforcement of the Act. This provision has the purpose and effect of discouraging physicians

from providing abortions for fear that the physician will be subject to enforcement proceedings because enforcement officials disagree with the physician's best medical judgment as set forth in the report.

98. Sections 3214(a) and 3214(h) establish reporting requirements for individual abortions and abortion complications. The definition of "medical complication" in 3214(h) is vague and overbroad, and the matters required to be reported in connection with a complication report serve no public health-related purposes.

99. Section 3214(a) requires that a report of each abortion performed be filed containing, among other things, identification of the referring and performing physicians. Such information serves no public health purpose and serves only to intimidate and deter physicians from referring or performing abortions for fear of public exposure and harassment.

100. Section 3214(a) requires a physician who has performed an abortion pursuant to Section 3211 to report the basis for his medical judgment that the abortion was necessary to prevent either the death of the woman or to prevent the substantial and irreversible impairment of a major bodily function. Under this section, a physician who has been excused from compliance from any provision because the abortion was performed due to medical emergency must report the basis of his or her medical judgment that a medical emergency existed. Further, this provision requires that all physicians report the tests performed and the results of those tests to determine gestational age, and that each physician report whether the abortion was performed on a married woman, if so, whether the woman informed her spouse, and if she did not, the reason she did not. This provision serves no public health purpose, is an unjustified intrusion into the physician-patient

relationship, interferes with the physician's exercise of his or her best medical judgment, and will result in increased costs, thereby creating an undue burden on women who seek abortions.

101. Section 3214(h), requiring that a physician's report of all complications resulting from an abortion be filed with the Department of Health, provides that the name and address of the facility where the abortion was performed must be listed. This provision exposes abortion facilities to harassment and unfair treatment by Commonwealth officials as well as persons opposed to the performance of abortions.

102. Section 3214(e)(1) states that the Department of Health shall prepare a comprehensive annual statistical report of the non-public information provided under sections 3214(a) and 3214(h). However, section 3214(e) states only that the Department's report shall not lead to the disclosure of the identity of any person filing a report or about whom a report is filed.

103. The language of this section, taken together with sections 3214(a) and 3214(h), could be interpreted to permit the Department in its annual report to identify performing and referring physicians of abortions, as well as the facilities in which the abortions were performed, exposing those identified to harassment or violence and, in the case of physicians, loss of hospital and other professional privileges.

104. Identification of physicians and facilities in connection with reports filed pursuant to sections 3214(a) and 3214(h) may result in heightened harassment and abusive treatment. Much of the information sought in these sections serves no health-related goal, is vaguely defined and is intended to discourage the performance of abortions.

VI. *First Cause of Action*

105. Plaintiffs hereby incorporate by reference Paragraphs 1 through 104 above.

106. The Act denies the right of privacy guaranteed by the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the United States Constitution in that it:

(a) imposes direct, substantial, and undue burdens on the exercise by women in Pennsylvania of their right to choose to terminate a pregnancy by means of abortion; and

(b) imposes direct, substantial and undue burdens on the right of a physician to practice medicine and to provide counseling, education and other services in accordance with that physician's medical judgment and with currently accepted medical standards.

VII. *Second Cause of Action*

107. Plaintiffs hereby incorporate by reference paragraphs 1 through 106 above.

108. The criminal and other penalty provisions of the Act fail to provide adequate notice as to the precise nature of conduct prohibited, thereby inhibiting the exercise of constitutionally-protected rights and inviting selective prosecution. They are, therefore, void for vagueness because they deprive plaintiffs and their patients of the due process of law, in violation of the Fourteenth Amendment to the United States Constitution.

VIII. *Third Cause of Action*

109. Plaintiffs hereby incorporate by reference paragraphs 1 through 108 above.

110. The Act denies the right of informational

privacy guaranteed by the United States Constitution and by the Pennsylvania Constitution in that it requires plaintiffs and their patients to disclose personal matters of the most intimate, sensitive and private nature which are protected by longstanding and powerful expectations of confidentiality.

IX. *Fourth Cause of Action*

111. Plaintiffs hereby incorporate by reference paragraphs 1 through 110 above.

112. Section 3209 of the Act deprives plaintiffs' patients of equal protection under the law guaranteed by the Fourteenth Amendment to the United States Constitution and Article I §§ 1 and 26 of the Pennsylvania Constitution and abridges equality of rights under the law in violation of Article I §§ 28 of the Pennsylvania Constitution because it imposes burdens upon women's reproductive choices that are not imposed upon the reproductive choices of men.

X. *Fifth Cause of Action*

113. Plaintiffs hereby incorporate by reference paragraphs 1 through 112 above.

114. Sections 3206 and 3209 of the Act deprive plaintiffs of their rights to familial and marital integrity by forcing family members -- parents, children or spouses -- to participate in decisions in a manner contrary to their own moral judgments and best interests in violation of the First and Fourteenth Amendments to the United States Constitution.

XI. *Sixth Cause of Action*

115. Plaintiffs hereby incorporate by reference paragraphs 1 through 114 above.

116. The Act violates plaintiffs' rights under the First and Fourteenth Amendments to the United States

Constitution by compelling medical providers to communicate the Commonwealth's ideology and by requiring women seeking abortions to receive information setting forth the Commonwealth's view regarding abortion.

XII. *Irreparable Harm*

117. If the Act is allowed to take effect, plaintiffs and their patients will be subjected to immediate and irreparable injury for which no adequate remedy at law exists in the following respects:

(a) Plaintiffs will face criminal prosecution, license suspension or revocation and civil liability if they do not comply with the Act;

(b) Patients whose interests the plaintiffs represent will be discouraged, impeded and possibly prevented from obtaining the abortions they desire, and thus suffer physical, emotional, and other harm;

(c) The right of privacy accorded by the United States Constitution to a woman's decision whether to terminate a pregnancy will be violated for women seeking abortions in Pennsylvania;

(d) The right to equal protection under the law guaranteed to women by the United States Constitution and the Pennsylvania Constitution and the right to equality of rights under law guaranteed by the Pennsylvania Constitution will be violated;

(e) The rights of familial integrity, marital integrity and free speech accorded by the United States Constitution will be violated by operation of the Act;

(f) Minors in Pennsylvania will suffer emotional and physical harm to themselves and irreparable

damage to their families because of the parental consent provisions in the challenged statutes; and

(g) The right of plaintiff physicians to practice medicine and communicate with their patients in accordance with their best medical judgment and the right of their patients to receive complete, confidential and unbiased information will be violated.

WHEREFORE, plaintiffs ask this Court:

A. To issue a temporary restraining order or preliminary injunction restraining defendants, their employees, agents and successors from enforcing the Abortion Control Act;
B. To enter an order certifying this action as a class action for each class described herein and naming the respective parties as class representatives;
C. To enter judgment declaring the amendments to the Abortion Control Act to be in violation of the United States Constitution and permanently enjoining the enforcement of its provisions;
D. To enter judgment declaring the amendments to the Abortion Control Act to be in violation of the Pennsylvania Constitution;
E. To award plaintiffs their costs and attorneys' fees pursuant to 42 U.S.C. §§ 1988; and
F. To grant such other and further relief as this Court shall find just and proper.

/s/ _____
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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, et al.	:	**CIVIL ACTION NO. 88-3228**
v.	:	
ROBERT P. CASEY, et al.	:	

ORDER

HUYETT, J. JANUARY 11, 1990

Upon consideration of the parties' respective positions as expressed at the conference on this date attended by Thomas E. Zemaitis, Esquire, and Kathryn Kolbert, Esquire, attorneys for plaintiffs, and Kate L. Mershimer, Esquire, attorney for defendants, IT IS ORDERED that this court's preliminary injunction of May 23, 1988 in this action is clarified as follows:

Paragraph 3 of the preliminary injunction, enjoining the enforcement of certain provisions of Section 3214(a) of the Act applies and will continue to apply to Section 3214(a) as amended by the 1989 amendments to the Act. Act of November 17, 1989, No. 64, amending 18 Pa. Cons. Stat. Ann. §§ 3201-20.

Paragraph 6 of the preliminary injunction, enjoining defendants from implementing or enforcing any provision of the Pennsylvania Abortion Control Act of 1982 that contains the term "medical emergency" as defined in Section 3203 of the Act applies and will continue to apply to all provisions of the Act that contain the term "medical emergency," including, but not limited to, the

following provisions amended or added by the 1989 amendments to the Act: Sections 3205, 3206, 3209, 3210 and 3211(c).

IT IS SO ORDERED.

/s/ _____
Daniel H. Huyett, 3rd, Judge

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA; REPRODUCTIVE HEALTH AND COUNSELING CENTER; WOMEN'S HEALTH SERVICES, INC.; WOMEN'S SUBURBAN CLINIC; ALLENTOWN WOMEN'S CENTER; AND THOMAS ALLEN, M.D., on behalf of himself and all others similarly situated;	:	**CIVIL ACTION**
Plaintiffs,	:	
v.	:	**CLASS ACTION**
ROBERT P. CASEY, N. MARK RICHARDS, ERNEST PREATE, JR., personally and in their official capacities, and MICHAEL D. MARINO, personally and in his official capacity, together with all others similarly situated,	:	
Defendants.	:	

DEFENDANTS CASEY, RICHARDS, AND PREATE'S ANSWER TO THE AMENDED COMPLAINT

Defendants, Governor Robert P. Casey, Secretary of Health N. Mark Richards, and Attorney General Ernest Preate, by their counsel, submit the following Answer to the Amended Complaint in the above-captioned matter:

1-4. Paragraphs 1 through 4 contain conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

5-9. Paragraphs 5 through 9 are ADMITTED.

10. Paragraph 10 states a conclusion of law that requires no response.

11. Paragraph 11 is ADMITTED.

12. Paragraph 12 states a conclusion of law that requires no response.

13. It is ADMITTED that Robert P. Casey is the Governor of Pennsylvania. The remainder of Paragraph 13 states conclusions of law that require no response.

14. It is ADMITTED that N. Mark Richards is the Secretary of Health for the Commonwealth of Pennsylvania. The remainder of Paragraph 14 states conclusions of law that require no response.

15. It is ADMITTED that Ernest Preate, Jr. is the Attorney General of Pennsylvania. The remainder of Paragraph 15 states conclusions of law that require no response.

15. It is ADMITTED that Michael D. Marino is the District Attorney for Montgomery County, Pennsylvania. The remainder of Paragraph 16 states conclusions of law that require no response.

17. Paragraph 17 states conclusions of law that require no response.

18. Paragraph 18 is ADMITTED.

19-21. Paragraphs 19 through 21 state conclusions

of law that require no response; to the extent they are deemed factual, however, they are DENIED.

22-24. Paragraphs 22 through 24 state conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

25. It is ADMITTED that in 1988, 50,786 abortions were performed in Pennsylvania and reported to the Pennsylvania Department of Health. As to the remainder of the averments in Paragraph 25, defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments.

26. Paragraph 26 is ADMITTED with the exception that 6.1%, rather than 6.2%, of the abortions performed in Pennsylvania in 1988 were during the second trimester.

27. It is ADMITTED that an abortion performed earlier in a pregnant woman's term is safer than an abortion performed later in the term from the standpoint of mortality. As to the remainder of Paragraph 27, defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments because of the vagueness of the term "extremely safe".

28. Paragraph 28 is ADMITTED in part. It is ADMITTED that delay in performance of an abortion generally increases the health risk that women face in connection with the procedure to some degree, but it is further ADMITTED that such increased risks are not necessarily significant. As to the remainder of this paragraph, defendants lack sufficient knowledge to form a belief as to the truth of the averments.

29. As to the averment that physicians practicing at clinics operated by the plaintiffs are subject to the criminal and civil penalties contained in the Abortion Control Act of 1982, as amended, [hereinafter the "Act"],

such averments state conclusions of law that require no response. As to whether such physicians refer women to other physicians for abortions, defendants lack sufficient knowledge or information to form a belief as to the truth of the averment. The remainder of paragraph 29 is ADMITTED.

30-31. Defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments in Paragraphs 30 and 31.

32. It is DENIED that plaintiffs provide abortion services to women who need immediate abortions due to a medical emergency. As to whether the plaintiffs provide abortion services to women who travel long distances to obtain such abortions, defendants are unable to respond due to the vagueness of the term "long distances." As to the remainder of the averments in Paragraph 32, defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments.

33. Paragraph 33 states a conclusion of law that requires no response; to the extent it is deemed factual, however, it is DENIED.

34. As to the averment that the Act is the only provision of law enacted by the General Assembly that provides detailed regulation of a particular surgical procedure, such averment states a conclusion of law that requires no response. The remainder of Paragraph 34 is DENIED.

35-39. Paragraphs 35-39 state conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

40. Paragraph 40 states a conclusion of law that requires no response.

41. Paragraph 41 is ADMITTED to the extent that plaintiffs have provided statistical information concerning M.D.s. Nevertheless, plaintiffs have not provided

information about D.O.s who are also obstetricians/ gynecologists.

42. It is ADMITTED that some women who seek to obtain an abortion in Pennsylvania may have to travel distances that could range between 50 to 100 miles. Otherwise, defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments.

43. Defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments and, therefore, they are DENIED.

44. It is DENIED that women necessarily will be required to take two trips to plaintiff providers or other medical providers due to the 24-hour waiting period. Otherwise, as to the remainder of the averments in Paragraph 44, defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments.

45. As to the allegation that the 24-hour waiting period mandated by the Act serves no legitimate state interest, such averment states a conclusion of law that requires no response. To the extent it is deemed factual, however, it is DENIED. As to the remainder of the averments in Paragraph 45, defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments.

46-47. Defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments and, therefore, they are DENIED.

48. Paragraph 48 is DENIED.

49. Paragraph 49 states a conclusion of law that requires no response. To the extent the averments are deemed factual, however, they are DENIED.

50. Paragraph 50 states conclusions of law that

require no response.

51. It is ADMITTED that sound medical practice requires a physician to have an informed consent dialogue with each patient. As to the remainder of the averments in Paragraph 51, these averments state conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

52. Paragraph 52 is ADMITTED with the exception that it is DENIED that the Pennsylvania law governing abortions prohibits a physician from exercising his or her sound medical discretion.

53-54. Paragraphs 53 and 54 state conclusions of law that require no response.

55. Paragraph 55 is DENIED.

56-57. Paragraphs 56 and 57 state conclusions of law that require no response; to the extent they are deemed factual however, they are DENIED.

58. Paragraph 58 is ADMITTED.

59. Paragraph 59 states conclusions of law that require no response.

60-61. Paragraphs 60 and 61 state conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

62. Paragraph 62 states conclusions of law that require no response.

63-64. Paragraph 63 and 64 state conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

65. Defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments.

66. Paragraph 66 states a conclusion of law that requires no response; to the extent it is deemed factual, however, it is DENIED.

67. Paragraph 67 states a conclusion of law that requires no response.

68. It is ADMITTED that the Supreme Court of Pennsylvania has not issued implementing rules regarding Section 3206(f) of the Act. It is DENIED that pregnant minors availing themselves of the judicial bypass procedure cannot be sure that their rights to confidentiality and expedited consideration will be preserved. Defendants lack sufficient knowledge or information to form a belief as to whether the Common Pleas courts of "many" counties are now straining under the burden of overloaded dockets and a shortage of judges and court personnel. Defendants are unable to ADMIT or DENY whether the trial courts or the appellate courts of the Commonwealth of Pennsylvania are prepared to effecttuate Section 3206(f) to assure expedition and confidentiality due to the vagueness of the term "prepared to effectuate"; nevertheless, defendants maintain that the trial and appellate courts of the Commonwealth of Pennsylvania are required to obey all Commonwealth laws. As to the remainder of the averments in Paragraph 68, they state conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

69. Paragraph 69 states a conclusion of law that requires no response.

70. Paragraph 70 states a conclusion of law that requires no response.

71. Paragraph 71 states a conclusion of law that requires no response; to the extent the averments are deemed factual, however, they are DENIED.

72. Defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments in Paragraph 72, with the exception that it is DENIED that Section 3209 will damage the integrity of marital relationships.

73. Paragraph 73 states a conclusion of law that requires no response; to the extent it is deemed factual,

however, it is DENIED.

74. As to plaintiffs' averments regarding possible delay when spouses are living apart, defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averment. The remainder of Paragraph 74 is DENIED.

75. Defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averment and, therefore, they are DENIED.

76. Paragraph 76 states a conclusion of law that requires no response. To the extent it is deemed factual, however, it is DENIED.

77. Paragraph 77 states a conclusion of law that requires no response.

78. Paragraph 78 states conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

79. Defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments in Paragraph 79.

80-82. Paragraphs 80 through 82 state conclusions of law that require no response. To the extent they are deemed factual, however, the averments are DENIED.

83. Paragraph 83 is ADMITTED.

84. Paragraph 84 states a conclusion of law that requires no response.

85. Paragraph 85 is DENIED.

86. Paragraph 86 states conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

87. Paragraph 87 states a conclusion of law that requires no response.

88. Paragraph 88 states a conclusion of law that requires no response. To the extent the averment is deemed factual, however, it is DENIED.

89. It is ADMITTED that modern technology now enables physicians to determine with extreme accuracy the gestational age of a fetus. The remainder of Paragraph 89 is DENIED is stated. It is ADMITTED that an experienced physician may be able, through discussion and physical examination, to generally determine the length of a pregnancy for purposes of choosing an abortion technique, but it is DENIED that all physicians will always be able to determine pregnancy lengths or gestational ages by such methods.

90. Paragraph 90 states conclusions of law that require no response; to the extent the averments are deemed factual, however, they are DENIED.

91-92. Paragraphs 91 and 92 state conclusions of law that require no response.

93. Paragraph 93 states a conclusion of law that requires no response. To the extent the averment is deemed factual, however, it is DENIED.

94. It is ADMITTED that abortion providers in the Commonwealth and the United States have experienced protests in various forms, including some of the methods identified in this paragraph. Otherwise, defendants, after reasonable investigation, lack sufficient knowledge or information to form a belief as to the truth of the averments in Paragraph 94.

95. It is DENIED that disclosure of reports filed by facilities receiving state-appropriated funds has the purpose and effect of penalizing physicians who perform abortions or medical providers by exposing them to violent actions, harassment, or interference with business relationships by persons who oppose abortion. As to the remainder of the averments in Paragraph 95, they state conclusions of law that require no response. To the extent such averments are deemed factual, however, they are DENIED.

96. Defendants, after reasonable investigation, lack

sufficient knowledge or information to form a belief as to the truth of the averments and, therefore, they are DENIED.

97-101. Paragraphs 97 through 101 state conclusions of law that require no response; to the extent they are deemed factual, however, they are DENIED.

102. Paragraph 102 states conclusions of law that require no response.

103-104. Paragraphs 103 and 104 state conclusions of law that require no response; to the extent they are deemed factual, however, the averments are DENIED.

105. Defendants hereby incorporate by reference their answers to Paragraphs 1 through 104 above.

106. Paragraph 106 states conclusions of law that require no response; to the extent the averments are deemed factual, however, they are DENIED.

107. Defendants hereby incorporate by reference their answers to Paragraphs 1 through 106 above.

108. Paragraph 108 states conclusions of law that require no response; to the extent the averments are deemed factual, however, they are DENIED.

109. Defendants hereby incorporate by reference their answers to Paragraphs 1 through 108 above.

110. Paragraph 110 states conclusions of law that require no response; to the extent the averments are deemed factual, however, they are DENIED.

111. Defendants hereby incorporate by reference their answers to Paragraphs 1 through 110 above.

112. Paragraph 112 states conclusions of law that require no response; to the extent the averments are deemed factual, however, they are DENIED.

113. Defendants hereby incorporate by reference their answers to Paragraphs 1 through 112 above.

114. Paragraph 114 states conclusions of law that require no response; to the extent the averments are

deemed factual, however, they are DENIED.

115. Defendants hereby incorporate by reference their answers to Paragraphs 1 through 114 above.

116. Paragraph 116 states conclusions of law that require no response; to the extent the averments are deemed factual, however, they are DENIED.

117. Paragraph 117 states conclusions of law that require no response; to the extent the averments are deemed factual, however, they are DENIED.

FIRST DEFENSE

The amended complaint fails to state a claim upon which relief can be granted.

SECOND DEFENSE

The Abortion Control Act of 1982, as amended in 1988 and 1989, does not violate the Constitution of the United States.

THIRD DEFENSE

Plaintiffs cannot satisfy that prerequisite to preliminary or permanent injunctive relief.

FOURTH DEFENSE

The Complaint fails to state a case or controversy under Article III of the Constitution of the United States.

FIFTH DEFENSE

Suit against the defendants in their personal capacities is meritless, frivolous, or vexatious.

Respectfully submitted,

ERNEST D. PREATE, JR.
Attorney General

By: /s/_____
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Deputy Attorney General

JOHN G. KNORR, III
Chief Deputy Attorney General
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Date: January 25, 1990

STIPULATION OF UNCONTESTED FACTS

Plaintiffs and Defendants, by their respective undersigned counsel, hereby stipulate and agree that, solely for purposes of this litigation, the following facts are uncontested. This stipulation is made without prejudice to any party's right to challenge the relevance of any uncontested fact to the matters at issue in this litigation.

1. Plaintiff Thomas E. Allen is a physician licensed to practice medicine in Pennsylvania and is an Associate Clinical Professor in the Department of Obstetrics and Gynecology at the University of Pittsburgh. He graduated from the University of Pittsburgh School of Medicine. He is an emeritus staff member of Magee Women's Hospital, is on the Consulting Staff of Presbyterian University Hospital, and is Medical Director of Women's Health Services Incorporated. He has been a Diplomate of the American Board of Obstetrics and Gynecology since 1954, has been a Fellow of the American College of Obstetrics and Gynecology since 1955, and a Fellow of the Pittsburgh Obstetrical and Gynecological Society since 1974. From 1972 to the present, Dr. Allen has been active in planning, establishing and administering Women's Health Services, Pittsburgh's first free standing abortion clinic. From 1970 to 1979, he was active in establishing and contributing services to the Pittsburgh Free Clinic. Dr. Allen has a private obstetrical and gynecological practice with one other specialist.

2. Plaintiff Planned Parenthood of Southeastern Pennsylvania (PPSP) is non-profit corporation providing comprehensive family planning, medical and counseling services, including birth control education, pregnancy testing and counseling, gynecological care, first trimester

abortions and vasectomies at medical clinics in Philadelphia, Montgomery and Delaware counties. The Center City Philadelphia clinic offers these services Monday through Friday. Abortions are performed on Wednesdays, Thursdays, Fridays and Saturdays at PPSP's Center City Philadelphia Clinic.

3. PPSP performs approximately 2,800 first trimester abortions a year. The abortion procedure presently costs full-payment patients $240 if the woman is 12 weeks or less from her last menstrual period. All fees cover only the direct costs of the procedure, including personal counseling, medical testing and examination, the abortion procedure, medical supervision during the post-surgical recovery, and a post-abortion examination.

4. PPSP charges $180 for abortions for women who are on medical assistance but whose abortions are not reimbursable by the state.

5. PPSP accepts state medical assistance reimbursement in lieu of direct payment for abortions for victims of rape and incest, and for women with life-threatening conditions. In 1987, approximately 53 of the abortions performed at PPSP were reimbursed by the Commonwealth.

6. In 1987, PPSP performed 359 abortions for women under the age of 18.

7. When a woman believing she is pregnant presents herself at a PPSP clinic, she is given a pregnancy test and examined by a nurse practitioner or physician. Women who believe they have just recently become pregnant are offered early detection by means of a blood test or special urine test. Once it is determined that she is pregnant, the woman is encouraged to participate in an individual options counseling session with a PPSP counselor.

8. Options counselors are volunteers or staff

counselors who have completed a special training program under the supervision of PPSP counselors and other senior staff. This training program consists of 43 hours of group sessions that focus on factual information regarding adoption, abortion, contraception and referral resources. The course also gives participants the opportunity to evaluate, explore and share their attitude and feelings. The course is certified by Temple University. Participants receive four CEU credits for completion of the training.

9. Abortion counselors are members of PPSP's counseling staff or college student interns working under the supervision of a staff counselor. These counselors have college backgrounds and experience in a health or social services related field. All have had on-site training in pregnancy counseling and abortion care and are required to participate in ongoing in-service training.

10. Each PPSP client participates in an individual abortion counseling session on the day her procedure is scheduled. In this session, the counselor and the woman discuss the women's medical history, personal situation and feelings about abortion. The counselor explains the abortion procedure and its risks. Post-abortion care and contraceptive plans are also explored. If the client has been accompanied to the clinic by a person she wishes to involve in the counseling, that person will be included in part of this session. In some cases the abortion counselor will serve as the support person and accompany the woman through the procedure.

11. PPSP counseling sessions for minors are more extensive, to assure that minors are informed of all options, and are making a free and informed choice. In the course of the counseling session, minors are given detailed information on the procedure and its risks. Minor women are also counseled on future contraceptive care. When a minor does choose to involve a parent or

other supportive adult such as an aunt, guardian or older sibling, the counselor will first meet privately with the minor. Then, at the counselor's discretion and with the minor's consent, the parent or adult will be brought in for joint counseling.

12. Plaintiff Reproductive Health and Counseling Center (RHCC) is a for-profit corporation in Chester, Pennsylvania, which operates a clinic that performs approximately 2,900 first and early second trimester abortions annually.

13. RHCC employs a staff of approximately four physicians, one nurse practitioner, and two full-time and two part-time counselors. Abortions are performed on Tuesday, Wednesday and Friday afternoons. Additional counseling services are available by appointment.

14. First trimester abortions (up to 12 weeks from the last menstrual period) with local anesthesia cost RHCC clients $220. For abortions from 12 to 16 weeks from the last menstrual period the cost is $375, plus an additional $70 for a required ultrasound.

15. If RHCC's clients are eligible for medical assistance reimbursement, RHCC seeks reimbursement from the Commonwealth. In 1987, RHCC was reimbursed for no more than 20 such abortions. The reimbursement rate was $59.50 to the clinic and $81.50 to the physician.

16. Where a client receives medical assistance from the state but is not eligible for medical assistance for an abortion, RHCC provides a $50 cost reduction for first trimester abortions with local anesthesia.

17. While RHCC's clients come primarily from Delaware, Philadelphia, Chester and Bucks counties, approximately 3-4% of its clients come from areas in excess of three hours travelling time.

18. In 1987, RHCC performed abortions on 349 minors. Approximately 60% of these minors were

accompanied by a parent. All minors who choose not to be accompanied by a parent are required to bring a responsible adult with them to RHCC who will stay in the building as long as the minor is there and will accompany the minor home.

19. A women's first contact with RHCC is usually by telephone. Women who call RHCC may or may not have had a pregnancy test prior to calling. Before any appointment is made, she must have had a positive pregnancy test. Telephone counselors refer the woman to RHCC or to the agency closest to her home or place of work for the test.

20. If a woman has a positive pregnancy test and wants to terminate the pregnancy, RHCC will schedule an abortion appointment, usually within one week's time. If the woman indicates uncertainty about her decision, the telephone counselor will recommend her making an appointment to talk further with an options counselor about her decision.

21. RHCC strongly urges options counseling for all minors who have not involved their parents in the decision.

22. In an options counseling session, an RHCC counselor talks with the woman about her feelings about her pregnancy. The purpose of the session is to let the woman know about each of the three options available to her: carrying to term and keeping the child, carrying to term and giving the child up for adoption, and abortion. Where appropriate, the woman is urged to talk about these options with supporting family members and friends. The role of the counselor in these sessions is to support the decision of the woman and to provide information that would be necessary as she acts on her decision.

23. Pre-abortion counseling at RHCC, which each woman must participate in on the day of her abortion

and which is different from options counseling, involves a discussion of the woman's decision, a review of her medical history and a description of the risks and complications of the abortion procedure. The informed consent part of the session is done with groups of four women. The counselor describes the medical procedure, reviews the risks and complications, and answers questions or addresses concerns. RHCC also provides counseling to the person or persons who accompany women for abortions.

24. Pre-abortion and options counselors are trained and supervised by RHCC's head counselor who has nine years counseling experience.

25. Plaintiff Women's Health Services, Inc. (WHS) in Pittsburgh, Pennsylvania, is a non-profit health center providing fertility control education, pregnancy counseling, general counseling for individuals and couples, PMS counseling and treatment, contraceptive and gynecological care, public education and first and early second trimester abortions. WHS has a staff of approximately 75 people (including 8 physicians, 14 nurses and 33 counselors) and offers ongoing programs which are inclusive of approximately 2,700 client contacts a month.

26. Free pregnancy testing and counseling are available at WHS daily, Monday through Saturday. Abortions are performed Tuesdays, Fridays and Saturdays. Gynecology clinics are held on Wednesdays and Thursdays and any other day a patient's condition dictates. Once their pregnancy is diagnosed, clients usually schedule their abortions by telephone.

27. WHS provides approximately 12,900 free pregnancy tests and 7,000 first and early second trimester abortions each year. The abortion procedure as WHS costs as follows: $330 if twelve weeks or less from the last menstrual period; $430 if thirteen to fourteen weeks

from the last menstrual period; and $650 if fifteen to sixteen weeks from the last menstrual period. The fee includes the abortion procedure, laboratory testing, personal counseling, contraceptive care, pathological examination and medical supervision during the post-surgical recovery period.

28. If clients are eligible for medical assistance, WHS takes the necessary information and seeks reimbursement from the Commonwealth. Medical assistance is available only where the abortion is necessary because of life-threatening condition, or because the patient was a victim of rape or incest. In 1989, WHS was reimbursed for 46 such abortions.

29. Where a client receives medical assistance from the state, but is not eligible for medical assistance for an abortion, WHS nevertheless will discount the cost of the abortion. Last year WHS accommodated 1,170 clients who were unable to pay the full amount. WHS has never turned away any client seeking an abortion merely because of inability to pay.

30. WHS's clients come primarily from Allegheny County. In 1989, however, 909 of their abortion patients came from areas in excess of two hours traveling time (100 miles) from the clinic.

31. In 1989, 703 of WHS's abortion patients were under the age of 18. WHS presently encourages minors to bring a parent or other adult with them. Because WHS believes that parental involvement should be encouraged, clinic counselors are instructed to offer to speak with a minor's parents if the minor would prefer that to making direct contact herself. When minors refuse to inform their parents under any circumstances, their wishes are currently respected.

32. When a patient presents herself at the WHS clinic, she receives a pregnancy test and blood tests.

33. All women are required to have an individual

interview with a counselor on the day their abortion is to be performed. During this interview, a woman is counseled with respect to her options and her decision to have an abortion. Information regarding the risks and benefits of the abortion procedure and the patients' medical history is provided to her. In that connection, the counselor seeks to ensure that the woman is not unduly ambivalent about her decision and that she is not being coerced. In addition, the counselor discusses future contraceptive use with the patient.

34. If the client appears ambivalent about her decision, the counselor will refer her to one of the staff therapists and the abortion will be rescheduled to give the patient more time to consider her options. On occasion, the clinic will refuse to perform the abortion if convinced of a patient's continued ambivalence. This is rare.

35. When a parent accompanies a minor seeking an abortion, WHS first counsels the minor with respect to her options and her decision to have an abortion, and also provides her with information on future contraceptive use. The parent is then asked to join the minor, at which time the abortion procedure and possible complications are described. The counselor also answers any questions they might have. An informed consent form is then read out loud to the parent and minor while they follow along with their own copies. Each then signs the form in the medical record.

36. Options counseling is provided on the day of the procedure by WHS paraprofessional counselors who are selected on the basis of personal qualifications and maturity.

37. Extensive and intensive problem pregnancy counseling is available at WHS at no charge to clients either before or after a decision with respect to an abortion has been made, regardless of what that decision

may be. Personal counseling is also available after the abortion procedure and clients are encouraged to take advantage of the service.

38. At present, WHS's director of personal counseling holds a Ph.D.

39. Personal counselors at WHS are professional therapists who have at least five years of clinically supervised experience at the master's degree level or above.

40. Both paraprofessional and professional counselors at WHS are required to begin their employment with a week of classroom preparation, consisting of approximately 35 hours of medical and counseling orientation to the abortion clinic. This instruction is provided by the associate medical director, director of counseling, and director of clinic services.

41. The medical information to be presented is developed under the supervision of a physician, the WHS associate medical director. The counseling protocols are developed and presented under the supervision of the director of counseling who holds a Ph.D. from the University of Pittsburgh. WHS also has an ongoing training module comprised of monthly in-services and quarterly individual supervision.

42. Plaintiff Women's Suburban Clinic (WSC) is a non-profit corporation in Paoli, Pennsylvania which operates a health care facility providing abortions, ongoing gynecological services, mini-laparoscopies, pregnancy testing, community education and counseling.

43. WSC performs approximately 3,350 first trimester abortions a year. Abortions are performed Tuesdays, Wednesdays and Thursdays.

44. Of the approximately 3,350 abortions WSC performed in 1987, 410 (12.25%) were performed on minors.

45. The fee for an abortion at WSC is $275. At

present WSC accepts state medical assistance reimbursement for abortions for cases of rape, incest and life endangerment. Approximately 40 such claims per year are reimbursed by the Commonwealth.

46. Appointments for counseling and abortions are made through WSC telephone counselors. A positive pregnancy test is required before an abortion is scheduled.

47. Depending upon patient interest and availability, appointments are made at WSC in one of the following ways:

a. If a woman requests counseling and the abortion on the same day, the first available appointment is given. There is often a one to two week wait in obtaining such an appointment. Approximately 70% of the abortion appointments are scheduled this way.

b. If a woman wants to see a counselor prior to the day of her abortion, a pre-abortion counseling session is made. Approximately 30% of the abortion appointments are scheduled this way.

48. All minors who have not informed a parent about their decision to have an abortion are asked to come to WSC for pre-counseling before the abortion appointment. This is done to give adolescents the opportunity to explore with a counselor their reasons for not involving their parents and affords them the time and opportunity to reevaluate that decision prior to the abortion.

49. A woman who calls WSC and expresses concern and confusion over an unwanted pregnancy is offered an opportunity to see a counselor to discuss her options. Resource information is available for options including keeping the child, foster care and adoption. Information concerning maternity homes is also available for those women who wish to carry their pregnancy to term.

50. All counseling at WSC is provided on an

individual basis by a trained counselor. All but one member of WSC's counseling staff have master's degrees; the other has a bachelor's degree with several years experience in counseling and family planning. All have backgrounds in various fields of human services.

51. It is WSC's policy that in order to counsel effectively, without becoming overstressed by the emotional demands of the job, counselors are not permitted to provide counseling for more than 20 hours a week.

52. WSC encourages that partners and/or parents be seen by the counselor during or after the counseling session. However, all clients are first seen alone by a WSC counselor.

53. Counseling at WSC is provided in an objective, nonjudgmental manner. The client's decision is reviewed and explored. The counselor also reviews the client's medical history, describes the abortion procedure, reviews birth control methods and goes over the informed consent form. Disclosure of medical risks and benefits is made as well. Also, post-abortion information, including what to do in the event of an emergency, is reviewed.

54. For women who express ambivalence over their abortion decision, the WSC counselor will further explore the issues. If the counselor feels that the woman is not sure of her decision, it is suggested that she take some time to reevaluate her choice. Additional counseling is available to assist the woman to come to a decision with which she feels comfortable.

55. Plaintiff Allentown Women's Center (AWC) is a for-profit corporation in Allentown, Pennsylvania which operates a clinic providing pregnancy testing and counseling, contraceptive and gynecological care and first trimester abortions.

56. AWC provides approximately 5,300 pregnancy

tests and 4,000 first trimester abortions each year.

57. Abortions are performed at AWC three to five days a week, depending on patient need.

58. The abortion procedure at AWC costs $280, with additional charges for services such RhoGam shots for women more than 12 weeks' pregnant, and general anesthesia. The fee includes personal counseling both before and after the abortion, the abortion procedure, laboratory testing, and medical supervision during the post-surgical period.

59. For patients who receive medical assistance from the Commonwealth, AWC's fee for an abortion is $225.

60. In the case of those medical assistance patients who require an abortion because of a life-threatening disease or because they were victims of rape or incest, AWC has received reimbursement from the state, so that no fee was charged directly to the patient. In 1987, AWC received less than $4,000 in medical assistance funds.

61. AWC's patients come primarily from an 18-county area in northeastern Pennsylvania encompassing the counties of Lehigh, Northampton, Carbon, Schuylkill, Luzerne, Lackawanna, Lebanon, Berks, Bucks, Pike, Chester, Lancaster, Susquehanna, Wayne, Monroe, Montgomery, Columbia and Wyoming. Many of these counties have no clinics or hospitals at which abortions are performed, AWC being the closest facility to which the women can come.

62. In 1987, 563 of AWC's abortion patients were 17 or under. Of these, 3 were age 13; 32 were age 14; 64 were age 15; 178 were age 16; and 286 were age 17.

63. AWC encourages its minor patients to involve their parents in the abortion decision and to bring a parent or other supporting adult with them at the time of counseling and the procedure. Clinic counselors are routinely available to speak with a minor's parents.

When a minor refuses to inform her parents under any circumstances, AWC respects those wishes.

64. In most cases, appointments for counseling and abortions at AWC are made through AWC's telephone counselors. A positive pregnancy test is required before an abortion will be scheduled. When a woman calls requesting an abortion, the telephone counselor collects personal data, menstrual history and medical history. If the caller is a minor, the telephone interview is more extended to assure that the minor fully understands what she must do and what the procedure will involve.

65. When a telephone counselor makes an appointment, pre-abortion instructions are given to the woman. These instructions include what the woman must do and what she must bring with her on the day of the appointment.

66. Any woman who calls AWC and expresses concern and confusion over an unwanted pregnancy is offered an opportunity to see a counselor to discuss her options. Resource information is available for options, including keeping the child, foster care and adoption. Information concerning prenatal care, welfare and support services is also available for those women who wish to carry their pregnancy to term.

67. A nurse practitioner or physician's assistant is available to examine all women and, where necessary, provide a pregnancy test and blood work-up. In addition, all women are required to have an individual interview with a counselor on the day their abortion is scheduled. In this interview, the abortion procedure and other alternatives are explained to the woman.

68. If the patient appears ambivalent about her decision to have an abortion, the AWC counselor will review options and suggest that the patient take more time to consider her decision before terminating the pregnancy. On occasion, the clinic has refused to permit

an abortion if, after consultation, the counselor and the clinic supervisor are convinced of the woman's extreme ambivalence, coercion, or that she is otherwise overly distraught. Sometimes, they will refer these women to outside counselors. Such instances are infrequent.

69. When a parent does accompany a minor to the AWC clinic, a counselor will first meet privately with the minor. After assuring that the minor has reached her decision to have an abortion freely and without coercion, the counselor will give the minor the option to continue the counseling session jointly with her parent, or to be counseled separately. In either case, the counselor will describe the procedure and possible complications as well as answer any questions they may have. The minor is then asked to sign an informed consent form.

70. When a minor chooses not to have a parent involved, AWC counselors explore and encourage the involvement of a supporting adult. Counseling of a minor who has not informed her parents is more extensive and includes a discussion of why she has chosen not to involve her parents.

71. The options counseling provided on the day of the procedure at AWC is conducted by paraprofessional staff counselors who are selected on the basis of personal qualifications. Most of the counseling staff have bachelor's degrees. Two are presently working on master's degrees. All have backgrounds in various fields of human services.

72. All of AWC's counselors are required to begin their employment with at least a week of orientation. Instruction is provided by the Director, the nurse practitioner, the Patient Services Coordinator and other counseling staff. During the first several months of work, the new staff has frequent meetings either on an individual basis or as a group with administrative staff to reinforce correct integration of medical information and

continued development of interviewing skills.

73. All medical information is developed and presented under the supervision of a physician who is AWC's medical director. The counseling protocols are developed under the supervision of the Patient Services Coordinator.

74. On March 25, 1988, Act. No. 31, amending the Pennsylvania Abortion Control Act of 1982, 18 Pa.C.S.A. §§ 3201-20, was enacted. Act 31 was scheduled to take effect thirty days after enactment, or April 24, 1988.

75. On November 17, 1990, Act No. 64, further amending the Pennsylvania Control Act of 1982 was enacted. Act 64 was scheduled to take effect sixty days after enactment, on January 16, 1990.

76. In 1988, 50,786 abortions were performed in Pennsylvania and reported to the Pennsylvania Department of Health.

77. Of the 50,786 abortions performed in Pennsylvania in 1988, 47,548 (93.6%) were performed within the first three months of pregnancy.

78. Patients under the age of 18 accounted for 11.6%, or 5,888 of the abortions reported in Pennsylvania in 1988.

79. Of the 50,786 abortions performed in Pennsylvania and reported to the Department of Health, 47,802 were performed on Pennsylvania residents. Residents of other states and territories accounted for 2,975 abortions, and residents of other countries accounted for 9. Of the 1988 abortion patients residing in Pennsylvania, 15,269 (30%) resided in Philadelphia; 7,337 (14%) resided in Allegheny County; 2,863 (6%) resided in Montgomery County, 2,270 (4%) resided in Delaware County; and 2,141 (4%) resided in Bucks County.

80. Of the 50,786 abortions performed in Pennsylvania and reported to the Department of Health

in 1988, 1 was performed on women age 11 or less; 20 were performed on women age 12; 113 were performed on women age 13; 377 were performed on women age 14; 855 were performed on women age 15; 1,702 were performed on women age 16; 2,820 were performed on women age 17.

81. Of all abortions performed in Pennsylvania in 1988 and reported to the Department of Health, 50,256 involved a dilation, evacuation, and curettage procedure. Intrauterine saline instillation accounted for 471 abortions. Intrauterine prostaglandin instillation was the procedure for 41. One abortion was performed by a hysterotomy procedure, and none was performed by hysterectomy.

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, et al.,	:	
	:	**C.A. 88-3228**
Plaintiffs	:	
	:	**(Judge Huyett)**
v.	:	
	:	**(Class Action)**
ROBERT P. CASEY, et al.,	:	
	:	
Defendants	:	

. . . . . .

SUPPLEMENTAL STIPULATION OF UNCONTESTED FACTS

Plaintiffs and Defendants, by their respective undersigned counsel, hereby stipulate and agree that, solely for purposes of this litigation, the following facts are uncontested. This stipulation is made without prejudice to any party's right to challenge the relevance of any uncontested fact to the matters at issue in this litigation.[1]

82. During 1989, minor women received abortions at plaintiff clinics as follows:

RHCC:	14 years and under -	27
	15-17 years -	267

[1] The parties previously filed 81 stipulations of uncontested facts on July 6, 1990. Subsequently, the parties stipulated to additional uncontested facts. For ease in reference, these supplemental stipulations will commence with paragraph 82.

AWC:	13 years old -	4
	14 years old -	22
	15 years old -	71
	16 years old -	160
	17 years old -	257
WSC:	12 years -	1
	13 years -	6
	14 years -	15
	15 years -	27
	16 years -	66
	17 years -	119
PPSEP	12 years -	2
	13 years -	14
	14 years -	27
	15 years -	80
	16 years -	122
	17 years -	189
WHS	12 years -	2
	13 years -	11
	14 years -	33
	15 years -	117
	16 years -	226
	17 years -	314

83. The risk of death from an abortion is dependent upon numerous factors, which factors include length of gestation, the type of procedure used to perform the abortion, the medical condition of the patient, and the skill of the physician performing the abortion.

85. WHS does not perform abortions after 17 weeks gestation.

86. At Magee, an ultrasound or sonogram is used to determine gestational age for pregnancies beyond 12

weeks.

87. At WHS, an ultrasound or sonogram is used to determine gestational age for any pregnancies beyond 14 weeks.

88. None of the plaintiffs have physicians who perform abortions without the physicians talking to the women prior to the abortion procedure.

89. Dr. Allen always does some counseling with his patient prior to a procedure and goes over the informed consent form with them.

90. Both WHS and Magee take a patient's history prior to performing an abortion.

91. In Dr. Allen's private practice, a patient completes a history form, which is sort of a health questionnaire, which is then amplified by a nurse's questions and further amplified by the physician when he sees her.

92. At WHS, the patient completes the history form, which is gone over by a counselor, and then the physician reviews it prior to performing the abortion.

93. Dr. Allen signs the Department of Health reporting forms for Magee but WHS uses his signature stamp for such forms.

94. No abortion can be performed on a minor at Magee without a parent's written consent.

95. Approximately 30% of Dr. Allen's patients seeking abortions are minors.

96. If a parent comes with a minor for an abortion procedure at Magee, Dr. Allen will speak to the parent too. If a parent comes with a minor for an abortion procedure at WHS, a counselor speaks to the parent.

97. When a parent accompanies a minor at WHS, the parent is involved in the counseling session, and particularly as to informed consent. Fifty percent of the minors who go to WHS are accompanied by a parent.

98. If a patient is ambivalent about having an

abortion and decides to postpone the procedure to have additional counseling, that will cause a delay in the performance of an abortion.

99. Plaintiffs encourage minors to bring their parents with them to the clinics and plaintiffs further encourage parental involvement with a minor's decision concerning an abortion.

100. There can be delays in performing an abortion on a minor who chooses to wait for her parent to be able to come to the clinic, which delay can exceed 2 weeks.

101. If a parent accompanies a minor, WHS explains the abortion procedure and possible complications to the minor and the parent, reads the informed consent provisions out loud, and has both sign it.

102. At WHS the average counseling takes 20 minutes.

103. WHS has a hot-line for women to call if they have any unusual symptoms or problems after an abortion to make sure there is immediate treatment.

104. Abortion is another "pregnancy outcome", in addition to births and fetal deaths, upon which the Health Statistics Division gathers information.

105. WHS provides information to the National Abortion Federation and the Alan Guttmacher Institute, including information concerning complications and the frequency that WHS's patients report them or WHS observes them.

106. There are various methods for determining gestational age, including physical examination, patient medical history, and ultrasound.

107. All plaintiffs make a determination of gestational age prior to performing an abortion.

108. The plaintiff clinics utilize the following methods of determining gestational age at the following

charges:

RHCC: Pelvic examination $10.00
Ultrasound $70.00

AWC: Medical history and pelvic examination - cost included in $280 fee for abortion procedure

Sonogram - $50.00

WSC: (1) Date of last menstrual period as told to WSC by client; and (2) Pelvic examination by physician performing abortion just prior to starting the abortion.

Occasionally, when a client is unsure of her last menstrual period or is late in her first trimester, the physician will do a pelvic examination separate from the procedure of abortion.

PPSEP: Pelvic sizing is performed by the physician prior to each abortion procedure. This is included in the fee for the abortion. An ultrasound is performed on all patients in their last two weeks of the first trimester to determine gestational sizing. This is done by a staff RN or Medical Assistant whose pay per hour ranges from $8.60 to $13.60. Each ultrasound requires approximately fifteen minutes to perform. Other staff involvement would include telephone scheduling of appointment at $9 per hour and intake

procedure at $9.80 per hour. Cost to patient is $25 - $50. The clinic would incur additional costs for supplies and equipment.

WHS: Prior to the abortion, the length of the pregnancy during the first fourteen weeks is determined by the length of time since the first day of the last normal menstrual period. This is verified by pelvic examination prior to the performance of the abortion. No fee is charged for this examination. If the woman is uncertain of the date of her last menses or the date indicates the pregnancy is greater than fourteen weeks LMP, the length of pregnancy is determined by a pelvic examination at a fee of $30 and ultrasonography at a fee of $100.

109. Plaintiffs are unaware of any free standing abortion clinics in Pennsylvania that perform pregnancy termination procedures after the 18th week of gestation.

110. As to WHS, free pregnancy tests and counseling are available Monday through Saturday, but 95% of counseling services are provided on the same day of the abortion.

111. If a medical emergency resulting from an abortion performed at WHS occurs, an ambulance is called to take that person to a hospital.

112. Planned Parenthood performs sonograms if the gestational age is near the end of the first trimester.

113. Planned Parenthood refers women with medical problems that make them high-risk patients to hospitals.

114. Planned Parenthood encourages minors to bring a parent with them.

115. Many of Planned Parenthood's abortion patients come from referrals from the other clinics where they previously have received options counseling.

116. During options counseling at Planned Parenthood, the counselors discuss with the woman the option of keeping her baby or giving it up for adoption.

117. Approximately sixty-five percent of the minors bring a parent with them to the counseling session in Planned Parenthood's experience.

118. If the parental consent provision of the Act (§3206) goes into effect, Planned Parenthood will counsel parents who attend with their minor child at the same time they counsel the minor.

119. If the parental consent provision of the Act goes into effect, parents may receive counseling sessions at any of Planned Parenthood's clinics.

120. No physician has stopped performing abortions for Planned Parenthood because his/her identity was stated on the Individual Reporting Form to DOH.

121. Ms. Wall has no knowledge of any case where DOH released the identity of a physician who performs abortions.

122. Planned Parenthood collects information for its internal use concerning medical complications following an abortion.

123. It is typical for a woman to receive counseling about her options once she has her pregnancy diagnosed at one of Planned Parenthood's centers, and to receive counseling again at the surgical center in Center City.

124. Planned Parenthood advises minors (and others) that if anything unusual or any sort of complications occur to let Planned Parenthood know and

to come back for treatment or go to an emergency room.

125. The telephone counselors at WSC make appointments and receive clients but they do not counsel about pregnancy options.

126. Counselors at WSC start at $8.50 per hour and are all part-time employees.

127. WSC encourages minors to attend with a parent.

128. WSC does not perform abortions due to medical emergencies as defined by the Act or otherwise.

129. If an emergency occurs when performing an abortion at WSC, a crash cart is used to stabilize the woman and then, in all probability, the woman would be transferred to a hospital based upon the physician or medical director's decision.

130. If a parent comes in with a minor to WSC, the minor is first seen alone by the counselor and then the parent joins the counseling session.

131. Ms. Hollos, the Executive Director of WSC, knows of no physicians who have stopped performing abortions because their identity is on the Pennsylvania Individual Report of Termination of Pregnancy form.

132. WSC never uses a sonogram in determining gestational age; rather, that is determined by questioning the woman and a pelvic exam by a doctor. If an ultrasound is ordered, it is performed at another facility.

133. WSC maintains or collects internal data regarding complications that occur.

134. Telephone counselor's salaries at RHCC are between $6.00 and $6.30 an hour. For options counselors, they start at $6.30 an hour.

135. RHCC counselors are not required to have bachelor degrees.

136. If a woman receives options counseling and pre-abortion counseling at RHCC, such counseling occurs on different days, with options counseling being

available on Tuesdays and Thursday.

137. In general, RHCC supports and encourages parental involvement in the abortion decision where possible.

138. If a parent accompanies a minor to RHCC for the abortion procedure, the minor reviews the risks and informed consent provision in the group session while the waiting room counselor goes over that information, including possible complications, with the parent.

139. RHCC keeps statistics on complications.

140. No physician at RHCC has ceased performing abortions because their identity is listed on DOH pregnancy termination forms.

141. At RHCC, one physician works at a time during those hours of operation when abortions are performed.

142. The Abortion Medical History Form used by RHCC was being used prior io the 1988 amendments to the Act.

143. RHCC submits quarterly reports of complications to the National Abortion Federation.

144. Doctors at RHCC sign the individual reporting forms (Report of Induced Termination of Pregnancy) submitted to DOH immediately following the abortion procedure.

145. Approximately sixty percent of the minors that had abortions at RHCC in 1987 were accompanied by one or both of their parents. That percentage has decreased to approximately 50 percent.

146. There is no minimum education requirement for AWC's counselors.

147. AWC determines gestational age by a woman's menstrual history and pelvic examination and, if AWC is unclear of the length of the woman's pregnancy, it will do a sonogram. The fee for a sonogram is $50.00

and is frequently waived.

148. AWC does not accept state appropriated funds.

149. AWC provides information to the National Abortion Federation (NAF) regarding AWC's complication rate.

150. AWC, prior to 1988, advertised in the newspapers although it does not presently advertise there. AWC does advertise in telephone directories.

151. All of the plaintiff clinics advertise by one or more of the following methods: newspapers, radio, and telephone directories.

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, et al.,	:	
	:	**C.A. 88-3228**
Plaintiffs	:	
	:	**(Judge Huyett)**
v.	:	
	:	**(Class Action)**
ROBERT P. CASEY; N-MARK RICHARDS; ERNEST PREATE, JR; and MICHAEL DL. MARINO,	:	
Defendants	:	

STIPULATION OF VOLUNTARY DISMISSAL

Pursuant to the provisions of Fed. R.Civ. P. 41(a)(1), plaintiffs and defendants stipulate to the voluntary dismissal of Michael D. Marino, who has not appeared in the above-captioned action, as a defendant.

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EXCERPTS FROM TRIAL TRANSCRIPT,
JULY 30 THROUGH AUGUST 1, 1990

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, et al.	:	**CIVIL ACTION NO. 88-3228**
v.	:	
ROBERT P. CASEY, N. MARK RICHARDS, et al.	:	**Reading, Pennsylvania July 30, 1990 10:20 o'clock a.m.**

. . . . . .

NON-JURY TRIAL - DAY 1

• • •

[10] MR. ZEMAITIS: Your Honor, Dr. Davidson is being tendered as an expert in the practice of emergency medicine in Pennsylvania. Consistent with your rules of practice, I will read a brief statement regarding his qualifications, follow up with a few questions on qualifications. Dr. Davidson received his A.B. from Temple University in 1971 with a major in chemistry and he received honors. He graduated from Temple University Medical School [11] in 1975 and he graduated from the Wharton School of the University of Pennsylvania with a Master's in Business Administration in 1989.

His internship took place at the Medical College of Pennsylvania in Philadelphia and his residency also took

place at MCP.

Your Honor, I neglected to say that Dr. Davidson's curriculum is Exhibit 77 which is in the binders that we submitted.

Sir, if you would like to have that in front of you, that might be helpful.

THE COURT: Very well.

MR. ZEMAITIS: Dr. Davidson is licensed in Pennsylvania and in California to practice medicine. His residency was in the emergency medicine program at MCP. He is a diplomat of the American Board of Emergency Medicine, having become so in 1980, and he was re-certified by that board in 1990.

His hospital appointments include attending physician at the Hospital of the Medical College of Pennsylvania, associate at the Mercy Catholic Medical Center, Department of Emergency Medicine, and at the Jefferson Park Hospital affiliate staff, ICU attending staff.

Dr. Davidson is teaching, has academic appointments at the Medical College of Pennsylvania. I'll let him [12] describe those in more detail, but he currently has an academic appointment there.

DIRECT EXAMINATION

BY MR. ZEMAITIS:

Q Dr. Davidson, are you currently treating patients in emergency medicine?

A Yes, sir.

Q Where do you treat patients?

A Primarily in the Emergency Department at the Hospital of the Medical College of Pennsylvania in Philadelphia.

Q Approximately how many hours per year do you spend in clinical practice?

A I see patients in the emergency department about 600 hours per year, sir.

Q How would that compare to someone who was involved in full-time clinical practice in the emergency room?

A Full-time clinical practice of emergency medicine is generally considered to be approximately 2,000 hours a year of practice.

Q Dr. Davidson, as I said earlier, you're a Fellow of the American College of Emergency Physicians. Would you describe the process that you undertook to become a Fellow of the American College?

A A Fellow of the American College of Emergency Physicians is first of all a diplomat of the American Board of Emergency [13] Medicine. That is, that physician is certified in the specialty by the American Board of Emergency Medicine, which is one of 23 recognized specialty boards.

In addition, a Fellow of the American College of Emergency Physicians must have sufficient career and specialty accomplishments that rise to a level for election to the rank -- to the category of Fellow and there is a laundry list which includes publication in learned journals, presentation at national meetings, participation in organizations, both locally, regionally and nationally, etcetera.

Q You're also a diplomat of the American Board of Emergency Medicine. Could you describe the qualifications for that position?

A The American Board of Emergency Medicine is one of 23 recognized specialty boards that certifies physicians. The process for certification by the American Board of Emergency Medicine includes recognition of previous practice and training and then successful completion of both a written examination and an oral examination. Certification is limited to ten years and recertification is required every ten years.

Q Dr. Davidson, could you describe your teaching

duties at MCP?
A The teaching of clinical medicine is very much a master- [14] apprentice type of relationship and I teach medical students in the clinical years and house staff, interns and residents at the bedside with the patients that I see in the emergency department. I also, to a much lesser extent, teach informal didactic settings from a podium, in a lecture hall or classroom, and do a great deal of one-to-one or one-to-two teaching in emergency medical services pre-hospital care.
Q Is all of your teaching responsibility in emergency medical services?
A It's all in emergency medicine and related subspecialties such as emergency medical services.

MR. ZEMAITIS: Your Honor, we'd tender Dr. Davidson as an expert in the practice of emergency medicine in Pennsylvania.

THE COURT: Any objection or any voir dire?

MS. MERSHIMER: No, your Honor.

THE COURT: Your motion is granted.

BY MR. ZEMAITIS:
Q Dr. Davidson, in your practice of emergency medicine, how do you define a medical emergency?
A Well, a medical emergency is any medical condition that requires intervention, usually both diagnosis and treatment, in an emergency kind of fashion, usually within minutes, seconds or minutes, you need to intervene quickly.
Q Is that a definition that is used among medical emergency [15] physicians, generally?
A I think so. I think that's a generally accepted operative definition.

* * *

Q I have placed before you, Dr. Davidson, the codified

version of the Emergency Medical Services Act which is found at 35 Purdon's Statutes, Section 69-22. Is there a definition in there of medical emergency or emergency?
A There's a definition here in the act of emergency, yes.
[16] Q Would you read that definition for us?
A It reads: "A combination of circumstances resulting in a need for immediate medical intervention."
Q Is that definition of emergency consistent with the definition you use in your practice as an emergency physician?
A Yes, I think so, it's -- immediate is seconds to minutes, yes.

* * *

[17] In your opinion, Dr. Davidson, is the definition of medical emergency in Section 3-203 of the Abortion Control Act consistent with the definitions of medical emergency that you just provided in your testimony?
A No, it's not.
[18] Q And why not?
A Well, I find this definition to be confusing and using terminology which in this context seems to me to be -- create absolute standards, and that's unfamiliar to me.
Q Let's look at some of the specific language of the definition. There's the term "serious risk" appearing three lines from the bottom of the definition. Do you see that?
A Yes, sir.
Q Is serious risk a term that has a standard meaning among emergency physicians?
A In point of fact, as a -- as a standardized terminology, it does not. Serious is more -- has a more relative -- relative term, something is more serious than something else, not a particular absolute sense.

Q The definition also talks in terms of a substantial and irreversible impairment, and I'd like to break that down to substantial impairment and irreversible impairment. Does the term "substantial impairment" have a standardized meaning among practitioners of emergency medicine?
A Substantial to me is a very unfamiliar term in this kind of context. I don't know -- I really don't understand what is sufficient to be substantial? Is it a major risk of a moderate kind of impairment or is it a very low risk, but nonetheless possible of a very serious kind of complication or problem.
[19] Q What about the term irreversible impairment, is that one that has a standard meaning among practitioners?
A Well, I think irreversible is a little -- is somewhat clearer than the -- than the other terms we've just talked about, although here again, irreversible for the physician may be -- may be pretty clear, but our patients often tell us that which we interpret one way is not really the way they under -- they understand it.

For example, I may say a wound has healed perfectly and yet the scar is considered an irreversible impairment by the -- on the part of the patient.
Q I gather from that, you're saying that people can differ on what constitutes an irreversible impairment?
A Yes.
Q Is that true within the medical profession that there may be differences?
A Well, again, I think some people -- as an emergency physician, I might not consider that scar to be much of an issue, yet the patient's psychiatrist, who feels that the patient has had some kind of problem ongoing because of it, may feel it's significant. So it's --
Q What about --
A -- situational.

Q Excuse me. What about the term "major bodily function," is that a term that has meaning to you?
[20] A All normal bodily functions are major or -- I don't know how to differentiate what's major and what's -- what's not major.
Q In your experience, in your clinical experience, has anyone ever talked to you in terms of a major bodily function versus a minor bodily function?
A It's not a term that's generally used among clinicians or really in giving advice to patients.
Q Would you have any way of determining for yourself what a major bodily function is versus a minor bodily function?
A Again, I can relatively, but not in an absolute kind of sense.
Q What do you mean by relatively?
A Well, it's very clear that, you know, loss of extremity is a bigger loss of a major bodily function than is that scar, but to my mind -- and that's why I spend time carefully doing plastic repairs of wounds -- one attempts to minimize any impairment of a bodily function.
Q In your practice of emergency medicine, the idea is to heal, whether it's major or minor?
A Correct.
Q Now, in your opinion, Dr. Davidson, what would the consequences be if this definition of medical emergency were to become applicable to emergency services in Pennsylvania?
A I think it would certainly create a degree of confusion [21] and likely delay care in those situations where it applied, namely to those pregnant patients who seek care.
Q Do pregnant women come into emergency rooms?
A Sure.
Q Why?
A Well, they come into emergency departments

because they have the same problems anybody has. They may have a minor, acute and recurrent illness, a severe sore throat or headache or something, something total -- or injury, trauma, that's not associated with the pregnancy. They may come to the emergency department because of a problem of some sort that may be related to the pregnancy, but -- such as urinary tract infection, which is not specific to the pregnancy, or they may come to the -- seeking medical care because of problems directly with the pregnancy.

Q What kinds of problems directly related to the pregnancy cause women to seek emergency medical services?

A Ectopic pregnancy is a common problem, spontaneous abortion, threatened spontaneous abortion, inevitable spontaneous abortion and complete spontaneous abortion.

Q Do any of these conditions that require women to come for emergency treatment ever require pregnancy termination as a result?

A Uhm, patients with inevitable spontaneous abortion typically undergo a termination of pregnancy, yes.

[22] Q what are the symptoms of inevitable abortion?

A Oh, inevitable abortion is characterized by vaginal bleeding, bleeding coming from the uterus, typically in association with some lower abdominal cramping, discomfort. In addition then the physician will find on examination that the uterine cervix has dilated, has begun to -- has begun to open up somewhat and it is at that point in association with the pain and bleeding that the -- that the term "inevitable abortion" is applied.

Q When a woman has the symptoms of inevitable abortion in your clinical judgment is it possible for the pregnancy to continue through the term?

A Those pregnancies, at least it's my understanding, go on and ultimately abort, miscarry in layperson's

terminology. Anyway, typically in current setting these patients are referred for elective D and C to empty the uterus.

Q Is that the course of treatment that occurs when a woman comes to the emergency room with a inevitable abortion?

A Well, it depends -- that's the typical ultimate treatment, yes. There may be variations that depend on the urgency and the urgency typically depends on the extent and amount of bleeding that the patient is suffering.

Q Who performs, in your clinical experience, the procedure when the inevitable abortion patient comes to the emergency room?

[23] A These patients are referred to obstetrician/gynecologists pretty uniformly for completion of performing an elective D and C.

Q Have you ever been required to perform the D and C procedure because of an emergency situation?

A I don't perform a complete D and C procedure, but a patient who is bleeding heavily with inevitable abortion, it is common practice to use an instrument to remove tissue so as to products of conception and potentially fetal parts so as to reduce the extent of bleeding.

Q What's the term "products of conception" mean?

A Well, we're talking about uterine contents that result from conception. It may be -- may include fetal parts, it includes parts of the placenta.

Q What happens to the woman if there is a postponement or what are the risks to the woman if there is a postponement of the procedure in the inevitable abortion situation?

A Well, the patient who is bleeding is at risk of bleeding into shock and requiring treatment for shock, fluid therapy and blood transfusion.

Q Are there any risks associated with blood transfusions that would not be encountered if there were no transfusion?
A If a transfusion -- every blood transfusion carries some risk. While the current state of the art has reduced that, there remains a risk of -- of infectious disease transmission [24] down the road, as well as acute risks from allergic or other kinds of immediate transfusion reactions. The major risks though in the current environment are infectious risks, particularly non-A, non-B, recently started to be called Hepatitis-C, which kills about 4,000 Americans annually and infects many more with a chronic illness.

There remains a small but real risk of passage of the HIV, human immuno deficiency virus which is associated with causation of AIDS.
Q Now, if there is a delay in the procedure to evacuate the uterus, the D and C procedure, what happens to the woman during that period of time?
A Well, presumably the patient would be observed during that period and the patient would have some pain from the continuing pressure on the uterine cervix and the patient can bleed, continues to bleed.
Q In your experience, Dr. Davidson, is inevitable abortion generally life-threatening?
A No, inevitable abortion is not generally life-threatening.
Q Does inevitable abortion typically result in a permanent impairment to the woman?
A Not a permanent physical impairment, no. That's -- patients recover from that.
Q In your opinion, Dr. Davidson, is inevitable abortion a [25] medical emergency requiring immediate medical treatment?
A Yes.
Q Would -- Dr. Davidson, do you believe that in your

experience inevitable abortion results in an irreversible impairment to patients who undergo it?
A No.

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BY MS. MERSHIMER:
Q Dr. Davidson, you said that an inevitable abortion requires immediate medical treatment?
A Yes.
Q So it must be done within seconds to a few minutes, is that correct?
A It requires -- it requires immediate attention within minutes to a few hours. Again, it varies, depending on the degree of patient's bleeding. There are patients who bleed [26] heavily enough that, in point of fact, we take them out of order and go see them immediately.

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Q Okay, have you ever performed any abortions due to a medical emergency?
A Uhm, again, and here I'm confused because I have removed pregnancies or part of the tissue associated with pregnancy from the uterus of women with inevitable abortions.
Q How many times?
A It's a regular occurrence, maybe a couple of times a year.
Q And when that happens is that always in the emergency room context where you work?
A That's where I work, so that's where it occurs, yes.
Q Medical emergencies that require immediate abortions are very rare, aren't they?
A Well, inevitable abortion is a regular occurrence. I mean, probably at my level of practice, I see it a couple,

you know, maybe a couple, three times a year, and we have enough exposure to it so that three dozen trainees get to see it more than five and less than fifty times in the course of a three-year training program. So it's a, regular, it's a regular occurrence.

[27] Q Well, when you say regular occurrence, about how many would you estimate your hospital sees in a year?

A Uhm, oh, I would guess in a 40,000 visit a year ER you're talking about once a week in an emergency department, give or take a little bit.

Q And an abortion is performed each time?

A The uterus is emptied, yes.

Q So when I say an abortion is performed, that's what you mean by the uterus is emptied?

A Well, I mean in each of those occasions the patient may not have heavy enough bleeding so that the emergency physician using a ring forceps will withdraw tissue. On the other hand, all of those patients go on to a D and C by a gynecologist, yes.

Q And these -- how soon after the women present themselves to the hospital -- wait, I take it -- well, let me back up. I take it they present themselves to the emergency room?

A Yes.

Q Okay and how soon after they present themselves to the emergency room is the abortion performed?

A Well, again, that's a feature of the patient's presentation. If the patient is bleeding heavily, it will be performed much sooner than if the patient is not bleeding as heavily. Nonetheless, these are performed in a non-scheduled fashion. It's not put off until -- till 8 o'clock the next [28] morning in the operating room.

Q In your expert report you said that it's -- you gave an example of an inevitable abortion where a pregnant woman presents herself in the emergency room context

experiencing copious vaginal bleeding, lower abdominal pain and progressive cervical dilation. How soon would the abortion be performed on such a woman? A patient bleeding like that who I assess is at risk of shock, if I see -- if I see or can feel tissue, I'm going to withdraw it with ring forceps in the ER and those patients will go to the operating room pretty quickly. Certainly we would like to try to get them there within 60, 90 minutes.

Q Okay. And if you don't perform the abortion that quickly for that woman then she's going to keep bleeding, isn't she?

A That's highly likely.

Q And she'll go into shock then, won't she?

A There's risk of that, yes.

Q And she'll probably die, won't she?

A Not necessarily, with optimum shock treatment.

Q Is there a risk that she'll die?

A Certainly.

Q Is it a serious risk that she'll die?

A Well, if there's a risk, and most pregnant woman are young and relatively healthy and, you know, it doesn't occur in the hospital very commonly in 1990. The patient would get [29] fluid resuscitated with -- with balanced salt solutions and then receive transfusion. And so shock treatment begins early, irreversible shock and death is very uncommon.

Q In these situations with inevitable abortions, in the cases you've seen when the women have presented themselves at the emergency room, have they wanted to have that baby?

A There are many patients who wish to retain their pregnancy, yes.

Q Would it be fair to say that for most abortions that are performed in the emergency context that the woman wants to have a child?

A Uhm, I -- I don't -- I really don't know that. I mean,

I can only speak of my own experience and certainly is mixed, it's not universal.
Q Well, what would be the majority of the cases?
A Uhm, in my experience, probably around a 50-50 division.
Q So at least 50 percent of the women that come into the emergency room experiencing the conditions of an inevitable abortion, they want an abortion anyway?
A They may or may not have confronted that issue; I don't really know. They may -- since I don't have a previous relationship with them, I don't know what they've been thinking.
Q If a woman -- if a pregnant woman would arrive at the emergency room ill and she's in a medical condition that you [30] believe an abortion is medically indicated, but you don't know if she wants to have the baby or not, would you consult with her first before performing an abortion?
A Certainly. I consult with all my patients before performing any procedure.
Q And would you get her informed consent to perform that abortion?
A I get my patient -- whenever possible, with the generally understood exceptions to the requirement for consent, I get my patients' consent before performing any procedure.
Q And would you attempt to determine the gestational age if you had the time?
A Again the only -- the only situation I can really envision is this situation of inevitable abortion. In my years of practice it's the only -- it's the only circumstance that I've personally confronted. And those -- those patients I usually don't have the resources to definitively determine gestational age. I do it on the basis of last known menstrual period which is as good as the patient's history is, but I don't usually have access to ultrasound or

titered levels of cumencorionic anatatropin (ph.) in the blood and so forth.
Q And that's because you don't have the time to determine gestational age because you have to immediately abort that child?
[31] A In the situation of the bleeding patient, yes.
Q Now, if this pregnant person that came in that was suffering from an inevitable abortion, if that person happened to be a minor would you attempt to get her parent's consent before performing the abortion?
A In the current -- in the current situation I speak to the, to the minor -- I speak to the patient and I -- and in my practice we commonly see parents or grandparents with that minor child. I certainly speak to family members and explain the situation, but it's my understanding and my practice, as I've had it explained to me by our hospital attorneys, that a pregnant patient consents for herself and so while I share information with the family, I seek the consent from my patient.
Q Do you perform any other surgical procedures on minors without obtaining their parents' consent first?
A In the case of the emergency exception to consent, all the time in patients with life-threatening or extremely urgent situations that occurs with regularity. In other situations, there are cases where patients have -- I see-- I've seen minors with wounds, both parents are at work, there is a caretaker who has not been given a legal document of some sort that indicates that they're responsible, but the patient and the caretaker indicate that they'd like the care taken -- care provided and delaying repair of the wound [32] worsens the outcome and so I will typically do what I believe to be best for the patient and repair the wound.
Q Let me see if I understand this. If it's a non-emergency situation and there is time to get the consent of the parent, you will do that?

A Well, I think, you know --
Q Could you just say yes or no?
A Well, it's not -- it's not a clear yes or no. What is time? A wound requires -- in order to reduce the risk of infection, wounds should be closed from six to eight hours from the time -- from the time that they occur. It may not be possible to get what I understand is legal guardians available to consent for repair of that wound. All wounds heal, it doesn't need to be sewn, but the outcome for the patient will be less salutary if I delay.
Q Well, do you just try first to contact the parents?
A Certainly.
Q And then if you can't contact the parents, then you use your best medical judgment about the treatment that should be provided under the circumstances?
A Yes, with proper advisement to our institutional, administrative and other authorities.
Q Well, what do you mean by that?
A Well, I --
Q You call up a lawyer first?
[33] A That's -- that's -- basically, that's an outgrowth of the current environment. I document in the record that I believe this is a situation that should receive care at this time and with this degree of urgency because in my medical opinion delaying is -- puts the patient at risk. The patient agrees with me but the competent legal guardian is not available to provide the formal kind of consent. I write that in the record and I, by our institutional policy, I must discuss that with the administrator on call who commonly has me discuss it with one of the people in the corporate law department.
Q Is closing a wound considered surgery?
A Certainly.
Q Now, if a pregnant woman presented herself in the condition of -- you diagnosed it as inevitable abortion and she was married, would you tend to notify her

spouse before performing an abortion?
A No, that's not something that I do.
Q Well, if a married woman ever presents herself in an emergency situation where treatment is needed, is there any attempt ever to notify the spouse that the woman is there?
A No. If the patient is able, is conscious and alert and able to consent for themselves, no. If the patient is unable to do so then certainly we attempt to reach next of kin, a spouse being the closest next of kin.
[34] Q Isn't it correct that most abortions that occur as a result of a medical emergency are performed in a hospital?
A I think that that's -- that's certainly correct in my experience.

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Q Okay, but you are saying that inevitable abortion is not, would not fall within the Pennsylvania's act definition of medical emergency?
A I -- I am saying that in my experience, inevitable abortion with significant bleeding which is a clinical condition that I see with regularity to my mind does not fit [35] in this definition and would cause me, especially since I understand criminal sanctions are involved, would cause me to delay or to seek additional consultation and would alter my current practice of -- of care.

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THE AUDIO OPERATOR: Would you state and spell your name for the record, please?
THE WITNESS: Thomas E. Allen, A-l-l-e-n.
MR. ZEMAITIS: Your Honor, Dr. Allen is tendered as an expert in the practice of obstetrics and

gynecology in Pennsylvania. Again I will give a brief synopsis of his qualifications. [36]

His curriculum appears as Exhibit 81 in plaintiff's exhibit binders, your Honor.

Dr. Allen attended college at the University of Pittsburgh where he received a Bachelor of Science degree in 1940. He attended medical school at the University of Pittsburgh where he received his degree in 1943. He served an internship at the University of Pittsburgh Medical Center in 1944 and a residency in gynecology at Elizabeth Steel Magee Hospital. That residency was interrupted by his military service and he returned to Magee Hospital in 1948, completed his residency in obstetrics and gynecology in 1951. He is an Emeritus staff member at Magee Women's Hospital today. I will note that the curriculum says active, that's a change that occurred fairly recently and I'll let Dr. Allen explain that.

He is on the consulting staff at the Presbyterian Hospital in Pittsburgh and he serves as Executive Medical Director of Women's Health Services, one of the plaintiffs in the case.

He has been a member of the faculty of the Department of Obstetrics and Gynecology at the University of Pittsburgh, serving as an associate clinical professor, an assistant clinical instructor and a teaching fellow.

He is a Fellow of the American College of Surgeons; has been since 1953. He's a diplomat of the American Board [37] of Obstetrics and Gynecology, became so in 1954, was re-certified in 1979 and again in 1989 and, again, your Honor,that does not appear in the curriculum,.

He is also a Fellow of the American College of Obstetricians and -- excuse me -- the American College of Obstetrics and Gynecology and he has served in that

capacity since 1955.

DIRECT EXAMINATION

BY MR. ZEMAITIS:

Q Dr. Allen, do you currently maintain a private practice of obstetrics and gynecology?

A I do.

Q And where is your office located?

A We have three offices; two of them suburban, the principal office is in Oakland, in Pittsburgh.

Q How many partners do you have in that practice?

A Currently I have only one.

Q Is he an obstetrician?

A Yes, he is.

Q In your private practice do you see patients, pregnant women who are intending to carry their pregnancy to term?

A Yes.

Q And do you treat those women throughout their pregnancy?

A Throughout their pregnancy.

Q Do you do deliveries on your patients who carry their [38] pregnancies to term?

A Not since my 70th birthday last year. We have a -- the medical staff has a bylaw that upon reaching that august age, they ship you upstairs and discontinue your -- your delivery privileges and major surgical privileges unless you have one of your younger colleagues scrubbed with you.

Q Is that the difference between active staff member and emeritus staff?

A Emeritus staff, correct.

Q And that's the position you assumed when you became 70 years of age?

A That's right.

Q During the years that you did do deliveries on your pregnant patients, how many deliveries would you

perform in the course of a year?
A Well, it varied from a maximum probably of 300 to a minimum of 150.
Q Dr. Allen, do you perform abortions?
A Yes, I do.
Q Where do you perform abortions?
A A few at Magee Women's Hospital and -- and a great many at Women's Health Services.
Q What role did you play in the founding of Women's Health Services?
A I was on the original committee that assessed the need [39] for such a service in Pittsburgh and raised the funds for establishment of the clinic as a nonprofit clinic and was its first medical director and have continued in that capacity since 1973.
Q When was Women's Health Service founded?
A We made the plans in '72, opened the doors in April of 1973.
Q Now, you said that there was a need for such service. What particular services are you talking about?
A For abortion services.
Q And has Women's Health Services continued to perform abortions since its opening?
A Yes, they have.
Q Have you been actively involved on the staff at Women's Health during that whole period of time?
A Yes, I have.

MR. ZEMAITIS: Your Honor, we tender Dr. Allen as an expert in the practice of obstetrician and gynecology in Pennsylvania.

THE COURT: Any objection or voir dire?

MS. MERSHIMER: No voir dire and no objection, your Honor.

THE COURT: Very well, your request is granted. He may testify in that area.

MR. ZEMAITIS: Thank you, your Honor.

[40] BY MR. ZEMAITIS:
Q Dr. Allen, what does the concept of informed consent mean to you as a physician?
A It -- it means assessing a patient's need for treatment and discussing with her the risks as well as the proposed benefits from the treatment that -- that is suggested and gaining her complete consent to that treatment.
Q What is the process that's undertaken to obtain informed consent from a patient?
A I or one of my designates sits down and talks with the patient about the problem for which she has sought treatment and make certain that she understands the risks and the probable outcome of that treatment and make certain that she joins in the desire to proceed with the treatment, whatever it might be.
Q Is that a process that takes place in a dialogue between you and the patient?
A It's a dialogue between, primarily between the patient and the physician or the physician, the patient and a designate whom the physician has confidence in.
Q In your experience, Dr. Allen, when you obtain informed consent from a patient, do you do it in a face-to-face conversation?
A Right.
Q In your opinion could you obtain informed consent, as you [41] understand it, through a telephone conversation with a patient?
A I could not.
Q Could you obtain an informed consent from a person, from any person giving informed consent over -- through the telephone?
A No, you have to have -- you have to have eye-to-eye contact with them to make certain that they understand and agree with what has been proposed.
Q How does that eye-to-eye contact facilitate your knowing that the patient understands and consents?

A It's largely a matter of body language, I believe, that you naturally have some people who are fearful when you explain risks to them, but so long as they -- at the end they come, you're satisfied that they understand what is proposed and agree that it should -- that it should be entered into willingly.

Q In your experience and opinion, Dr. Allen, is it consistent with standard medical practice to conduct an informed consent dialogue in person?

A Yes.

Q Would it be consistent with accepted medical practice to perform that dialogue by telephone?

A No, I couldn't do it by telephone.

Q Would it be acceptable to do it by mail, sending a form [42] and having it sent back?

A No.

Q If you were told by one of your patients who was referred to you by another physician that she had discussed all the procedures with another physician, that she had given her informed consent to that physician, would you rely on that in going forward with the medical procedure?

A I might do it if it were a colleague with whom I worked, for instance, one of my partners and he was not able to perform the -- I would still have the discussion with the patient, but I wouldn't have to go through all the ramifications that I know that he had done. But I couldn't do it with someone out in the field who may have been a referring physician.

Q When you say you couldn't, I take it that you would conduct your own informed consent dialogue?

A Yes, I would still do that.

Q And you would feel that was necessary in your medical practice?

A Right. It doesn't matter whether it's -- whether it's care of an obstetrical patient or care of a gynecological

patient either.

Q Now, are you aware that the Pennsylvania Abortion Control Act if it goes into effect would require that there be a 24-hour waiting period between the time a women is given the [43] information to obtain her consent in the performance of the abortion?

A Yes, I've read that in there.

Q In your opinion, Dr. Allen, is there any medical reason to delay a procedure, once a woman has decided to have an abortion and has given her informed consent to the abortion procedure?

A There is no reason for delay and actually there may be some harm produced from it.

Q How so?

A The patient comes into the clinic or to the hospital anticipating the procedure and it's not been an easy decision, as a rule, she's made the decision prior to that. She confronts harassment as she enters the clinic and from -- from the people who are trying to change her mind and comes in and has her counseling session with -- and it's quite evident for most of these people that they just need to have the risks explained to them because they've already reached the decision or they wouldn't be there. And then to make that woman go through a counseling session prescribed by act of the legislature that includes things in an attempt to deter her from that decision which she has made creates a more stressful situation for the woman, then she has to come back and do it a second time in order to have the procedure done.

[44] Q So let me make sure I understand. You're saying the combination of the mandated delay and the specific information required by the statute would in your opinion increase stress among the patients seeking abortions?

A In the -- on the part of the patient, correct.

Q And I also take it from your answer that in your

experience, most women who come to Women's Health Services for an abortion have already decided to have the abortion before they arrive there?
A Yes, they have.
Q Are there ever circumstances where women arrive having not made that decision ahead of time?
A Yes. Well, some women arrive at the clinic with ambivalent feelings, they -- because of teaching and some of the harassment that they've faced on the street coming in. They -- they have made a decision but that changes it a bit, or it makes them less certain of their decision, and that's the situation in which the counselor can spend more time with the patient and refer her to a personal counselor, if need be, who makes certain that this woman really wants to terminate her pregnancy before we go on. And some of these women do leave the clinic, do come back another day farther along in their pregnancy and with their mind definitely made up.
Q For those women who are ambivalent do you feel that it is [45] useful for them to have some additional time to reflect on the procedure?
A Yes, yes, but it's a small percentage. It's probably only about probably -- I don't know the exact figures -- probably only about five percent.
Q For a woman who shows no ambivalence or expresses no ambivalence, do you see any reason --
A No reason.
Q -- medically or otherwise for a delay?
A No reason for delay, that's correct.
Q Now, would delay of 24 hours -- and I mean just 24 hours at this point, Dr. Allen -- normally increase the risk to a woman's health in an abortion procedure?
A Normally it would not.
Q If the delay expands beyond 24 hours, is a point reached where the risks, the medical risks to the woman increase?

A Yes. Beyond -- beyond eight weeks of pregnancy there is an increased risk of complications that is about 30 percent for each additional week and there is a risk of mortality that is about 50 percent for each week of delay beyond eight weeks. Now, admittedly, the risk of mortality is extremely low, but it does increase with advancing pregnancy.

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[47] Q How does the mortality rate for abortion, even at 15 or 16 weeks, compare to the mortality rate for bearing children?
A It's seven -- depending on whose statistics you're reading, it's seven to ten times more dangerous to continue a pregnancy to term.
Q Do you know how the risk of abortion compares to other relatively minor surgical procedures, such as a tonsillectomy?
A It's about twice as safe as a tonsillectomy and about a hundred percent -- about a hundred times as safe as an appendectomy.

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Q Has ACOG taken a position on whether it's appropriate to mandate waiting periods for all women seeking abortion services?
A They have taken a position against that mandated waiting period.

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[48] Q . . . Could you give us a brief description of the counseling regimen as it occurs at Women's Health Services?

A The -- the procedure, the counselor who sits down with the patient and discusses the procedure, the risks, the expected outcome makes certain that she is not being coerced into this by some family member or somebody outside the counseling room and who secures her informed consent by reading to her, as a basis for the counseling, the consent as it exists in our chart, which we think it's fairly conclusive, and then describing for her any of the -- of the medical terms which the patient does not understand. That is all done prior to the patient's coming to the procedure room.

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[49] Q Now, you said that the person who counsels before the procedure will read a specific bit of information to the patient regarding risks.
A That's right.
Q Is that writing contained in standard documents that Women's Health Services uses?

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[51] Q Do you have a professional opinion, based on your experience at Women's Health Services, Dr. Allen, as to whether counselors are capable of giving information for informed consent and obtaining informed consent from patients?
A I -- I certainly believe that they're capable of it and probably do a better job than we physicians would do because that's their primary job.
Q Why do you conclude that they would probably do a better job than physicians in conveying the information?
A Because -- because they take more time and they're -- the counselors are all women who relate to women very well.

Q Are there other reasons why you think it's beneficial to use counselors to obtain informed consent rather than physicians?
A It's much more economic to pay a counselor who is a specially trained to do this to spend the time, it's economic of both times and dollars because it allows the physicians to devote their time in patient care with the -- with the knowledge that the needs of the patient have been met satisfactorily before she reaches the procedure room.
[52] Q In your experience has the practice of medicine grown more specialized as the years have passed by?
A Yes. I think it doesn't only pertain to medicine.
Q Okay. Do you find the use of counselors for the informed consent purpose to be consistent with this trend?
A Yes.
Q Do you find that the use of counselors to provide informed consent is consistent with accepted medical practice?
A Yes, it certainly is.
Q In your opinion that is consistent?
A In my opinion it is.
Q To your knowledge, Dr. Allen, has ACOG taken a position on whether the use of counselors is appropriate for informed consent?
A They have -- they have come out in favor of counseling, as has the American Public Health Association.
Q Now, you mentioned the category of personal counselor a few minutes ago and I want to explore that for a minute and make sure we understand. When do personal counselors get involved at Women's Health Services and what do they do?
A The -- the counselors have -- the abortion counselors have primarily been trained on the job by the personal

counselors. They do the individual patient counseling and if they detect any ambivalence or undue fear on the part of [53] women, some areas of some psychological problem that the patient may have, they will refer the patient to the personal counselor who is a trained psychologist or trained social worker, Master in social work, who can sit down with the patient and delve more deeply into whatever her problem may be that may not be related to the pregnancy that she has at all.

Q So that the personal counselor gets involved when the pre-abortion counselor detects a need for more involved counseling?

A That's right.

Q Do you know what percentage of women at Women's Health Services have or require personal counseling?

A I don't know, but it seems to me that in a -- in a day in which we see 40 or 50 patients, there may be three or four of them who -- who are referred to the personal counselor.

Q How long does the personal counseling session take?

A I don't know. It probably varies. It takes as long as it takes for that personal counselor to resolve the problem and sometimes they have to come back, you know, they have to come back for other sessions.

Q That would be when the ambivalence isn't resolved in the first --

A That's correct.

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[54] Q . . . Dr. Allen, in your obstetrical practice with patients who are intending to carry their pregnancy to term and have a child, do you typically inform them of the medical risks of the abortion procedure?

A No.

[55] Q Do you see any reason to inform them of the medical risks?

A There is -- there is none, the medical risk of abortion there certainly isn't, if she's anticipating the child to term.

Q Let me make sure I understand.

A You're not trying to change her mind.

Q If she is not going to have an abortion, there is no reason to tell her?

A No reason to do that, that's right.

Q How do you feel about the requirement that a woman who has decided to have an abortion must be told under this provision of the act the medical risks associated with carrying the child to term?

A I don't see any reason for it at all.

Q Do you think it's a helpful thing to do?

A No, I don't.

Q Could it be a harmful thing?

A It might strengthen her feeling that she should go ahead and have the abortion because the risks are less.

Q But if she's already decided to have the abortion you see no reason?

A Then there's no reason to do so.

Q There are a series of items that are set forth under the paragraph Arabic 2, reference to printed materials, reference [56] to medical assistance benefits, reference to the liability of the father of the unborn child for support, et cetera. In your experience, Dr. Allen, are these items that are part of the dialogue for securing the informed consent of a patient to a medical procedure?

A No, they're not.

Q How would you characterize these provisions of the statute?

A Well, they have to do with social and economic things which may or may not be available. There's some -- I mean, and legal things, also, which I don't feel

competent to advise a patient that she can get child support from the alleged father of the pregnancy.

Q Let me make sure I understand. Are you saying that this information, first of all, is not information that would be given for informed consent?

A That's right.

Q And it's not necessarily information that all women should be receiving?

A That's certainly true and it's -- I have some problems with it because I don't think that it's -- that it's always true, some of these things that are -- some of these statements here I don't think are really fact.

Q What statements would you think, Dr. Allen --

A That -- that there may -- well, I guess the "may" takes [57] that out of it, there "may" be available to the patient medical assistance and there may be available support from the father of the pregnancy.

Q In your experience, could telling a woman that there may be medical assistance benefits available mislead her?

A Yes, it could, and I have enough patients who have gone through pregnancy with very little support from either of these two sources.

Q Who otherwise might need that help?

A That's right, who do need it.

Q But the fact that they may be available did not in those cases turn into a reality, they were not --

A They were not available to them.

Q -- in fact receiving the benefits?

* * *

[58] Q In your opinion, Dr. Allen, is it the obligation of the counselor to try to persuade the person being counseled to one or another position?

A No. No, she should just find out how the patient

feels. She's not -- she's not there as a partisan for either position.

Q And in your experience do the counselors at Women's Health Services adopt that nonpartisan position in their counseling?

A Yes, they do.

Q Is that part of the training that the counselors go through?

[59] A That's part of their training.

Q In your opinion, Dr. Allen, if these items that are set forth in the statute were required to be incorporated into the counseling session, would that affect the nonpartisan nature of the counseling?

A Yes, in -- in -- it could because they sort of balance each other maybe a little bit if you gave the patients the statistics on the risks of carrying the pregnancy to term and then countered with some of this other extraneous material, why you'd probably come out about even.

* * *

Q Does the limitation of civil liabilities set forth in that subsection cause any concern for you in the context of good patient care?

A It -- it might abbreviate your -- on the part of some physicians -- the careful explanation and rendering of an adequate informed consent because it reduces their -- it eliminates their liability to malpractice civil suits if they include the things that are mandated.

Q So your concern is that other necessary information won't be conveyed to the patient?

[60] A Well, it -- it could, sometimes it might be short-shunted.

* * *

[61] Q Are you aware, Dr. Allen, that a violation of the informed consent provisions of the statute carries with it criminal penalties?
A Yes, I am.
Q Is there any other context you're aware of in which failure to provide informed consent information results in criminal penalties?
A No. Civil penalties, but not criminal penalties.
Q If the criminal penalties in Section 3205, the informed consent section of the statute, become effective, what impact do you think it would have on physicians who perform [62] abortions?
A I think it may deter some of my colleagues from providing the service.
Q What's the reason that you've concluded that?
A Well, they're a little more fearful of criminal accusations than they are of civil, because they're medical malpractice insurance tends to cover them pretty well for civil suits, but it has no coverage for criminal suits.
Q Have you discussed that with your colleagues?
A We've had several meetings between the time that the act was passed last fall and the time it was to take effect.

MS. MERSHIMER: Your Honor, I would object on hearsay grounds and ask that Dr. Allen's testimony on this point be stricken.

THE COURT: It's overruled.

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Q In your experience, do minors tend to seek help for pregnancy and pregnancy-related problems later in the pregnancy or earlier in the pregnancy than adult women?
[63] A Later.
Q In your experience, why is this the case?

A There's a certain amount of denial, they're not so well informed as to symptoms and signs of early pregnancy; they're frequently fearful of sharing this information adults, particularly parents. They might tell their best friend in junior high school, but a good percentage of them don't confide early in their parents.
Q For minors who seek abortions, what are the consequences of this delay in seeking medical treatment?
A They usually arrive -- as a group, they arrive a little bit later in their pregnancies.
Q Are they closer to the second trimester of pregnancy?
A Well, all the way up the line they're a little bit farther along in their pregnancies.
Q So there are larger percentages of minor women at later weeks seeking abortions --
A That's correct.
Q -- than there are adult women at later weeks?
A Right.
Q In your experience, Dr. Allen, are minor women capable of understanding the medical risks associated with abortion and giving informed consent to the abortion procedure?
A I think with a careful explanation of it by either a physician or a counselor, they can grasp the significant [64] points of it and given an informed consent.
Q Under Pennsylvania law, what's your understanding of whether -- today, that is, whether a minor woman can give informed consent for any procedure connected with her pregnancy?
A They can consent to continuing the pregnancy and they can consent to treatment for sexually transmitted diseases, but because of the Abortion Control Act, which is currently enjoined, if it were not enjoined they would not be able to do that.
Q To consent to abortion?

A That's right.
Q Now, in your experience, Dr. Allen, are minor women capable of knowing when parents should and should not be involved in the minor's decision-making process on abortion?
A They're much better informed of that than I am, or the counselor, or the State Legislature, I think.
Q In your experience, do they generally make responsible choices when they decide not to involve parents?
A Right, and most of the very young minors come to the clinic with their parent, with one parent, or at least a significant person. But there are some of them who just don't have that relationship, and they usually bring some other person with them who is older, but it doesn't have to be parent, it might be an older sister, grandmother.
[65] Q Dr. Allen, has ACOG taken a position on whether minors should be forced to involve parents in the abortion decision?
A They've taken a negative attitude to that.
Q So ACOG's position is that minors should not be required to involve parents?
A They should not be required, but it's desirable for them to notify their parents.
Q Is that consistent with your personal medical opinion?
A That's the way we feel too.
Q Dr. Allen, let me ask you a few questions finally about the husband notification provision of the statute. Is there any other statute or regulation you're aware of that requires a husband to be notified when a woman is about to undergo a medical procedure?
A No, adult woman, so long as she's conscious.
Q For example, if a woman chooses to have a tubal ligation that would render her sterile, does she need to notify her husband?

A No.
Q If a husband chooses to have a vasectomy that would render him sterile, to your knowledge is he required to notify his wife of that fact before having the vasectomy?
A He's not required. Most husbands and wives, if they have a good relationship, share this knowledge with their spouse.
Q Is it accepted medical practice, Dr. Allen, not to inform [66] a spouse when your patient is about to have a medical procedure?
A No, that's the responsibility of the patient, whether it's male or female, to notify whomever she wishes to. We don't discuss a patient's treatment with anyone but the patient, unless we have her request to do so.
Q So I take it you respect the patient's wishes with regard to confidentiality?
A Right.
Q Would a husband notification provision prior to abortion be inconsistent with medical practice as you understand it?
A It would be.
Q Why would that be?
A Because the wife is -- if I were to do it --
Q To require it, whether it be the patient or the doctor?
A Yeah, I think that it's inconsistent with other forms of medical treatment. If it applies only to abortion, then it certainly is not consistent with sound medical practice.
Q Has ACOG taken a position, Dr. Allen, with regard to husband notification provisions?
A They're opposed to husband notification.

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[67] BY MS. MERSHIMER:
Q Doctor, how many days a week do you work at

WHS, or Women's Health Services?
A About one a week.
Q And how many hours a day do you work?
A If I'm there -- if I work a full day, it's about seven hours.
Q And does that seven hours -- is that seven hours always performing abortions, or does that include breaks and lunch hour?
A That doesn't include much lunch hour, but it does include checking patients in the examining rooms, determining duration of gestation and --
Q And how -- I'm sorry. How many abortions do you perform a day, in an average workday?
A It varies. It's about -- it depends on how many doctors there are there, but it is usually about 15.
Q Sometimes 20?
A Sometimes 20.
Q And how many physicians do work a day at Women's Health Services?
A Usually two or three.
Q And they're all treating about 15 to 20 patients a day?
[68] A Well, we do abortions only three days a week and sometimes it's not a full day.
Q But aren't --
A I'm not there three days a week.
Q Do you know whether the other physicians are averaging about 15 to 20 abortions a day?
A I would judge that it may be closer to 15, it depends on the patient load.
Q And how much are you paid for performing an abortion?
A We're just on an hourly basis.
Q Well, what is that hourly rate?
A It's currently 175 an hour.
Q And is that true of all the physicians at Women's

Health Services?
A That's correct.
Q Now, do you normally know who the patient is before you perform the abortion on that woman at Women's Health Services?
A I look over the chart beforehand.
Q All right, you look over the chart, but you haven't met her before until you meet her in the --
A Until I walk into the -- well, sometimes we have, if we've been involved in determining what her period of gestation is in the examination room, prior to her being counseled. If she comes in with an inaccurate date or is [69] beyond 13 weeks by date, we will -- one of us will see her. It may not be the same physician who sees her in the procedure room, but one of us will see her.
Q So, you meet the woman for the first time either in the examination room or the procedure room?
A That's correct, except for a few of my private patients who come down there for the procedure.
Q What percentage of the patients do you meet for the first time in the procedure room?
A In the procedure, probably about 80 percent of them.
Q And how much time do you spend with the woman in the procedure room?
A During the procedure or prior to the procedure?
Q Both, why don't you break it down?
A All right, prior to the procedure, about five minutes--
Q And then --
A -- during the procedure, about ten minutes.
Q And do you see her at all after the procedure?
A In the recovery room we sometimes do.
Q Sometimes?
A We frequently do, yes.
Q If you don't, does another physician or nurse see the patient in the recovery room?
A The nurses usually take care of them in the recovery

room; we dispense all medication to them and see any problems [70] that may arise there during their hour or two-hour stay in the recovery room.
Q And when you -- if you see them in the recovery room, how much time do you spend with the woman?
A It varies, depending upon whether she's having a problem or not.
Q Well, what's the average time? What's the average time if there's no problem?
A No problem, maybe a minute.
Q If there's a problem?
A If there's a problem, it depends upon the problem.
Q Well, what are the problems that can occur?
A The most common problem is hematometra.

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[71] Q And how often does that problem occur?
A Probably in two or three percent of procedures.

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[73] Q You personally do the informed consent procedures for the abortions you perform at Magee Women's Hospital, is that correct?
A That's correct.
Q And --
A With help from my nurse practitioners in the office, whom I trust.

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[76] Q Dr. Allen, I'm handing you yet another black book. Would you turn to the exhibit that's marked Number 1? Are you familiar with Defendant's Exhibit No. 1?

A Yes.
Q Can you tell me what it is?
A It's Magee Women's Hospital informed consent for termination of pregnancy.
Q And is this a form that you have all women sign before you perform an abortion at Magee?
A Yes, this is gone over with them by the nurse in our office. And I've answered any questions that they might have about it.

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[77] Q Doctor, you've testified that informed consent should be face to face, correct?
A That's correct.
Q Is it possible to provide information over the telephone to a woman, and then follow it up with a face-to-face meeting another day?
A You mean to get a --
Q To obtain an informed consent?
A To obtain the informed consent. That should be possible, if you can have time to --
Q Thank you, Doctor.
A -- follow that -- yes.

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[80] A No, it was 1970 to '76, were their graphs. But the statistics are better now, but the ratio between early abortions and later abortions has not changed. We have fewer total -- a lower total mortality, it has continued to go down. The ratio between early abortions, which is almost zilch, and later abortions is still pretty much the same, it increases. It doubles every two years after eight to nine weeks.
Q Every two years or every two weeks?

A I mean every two weeks, yes.
Q You said that abortion is twice as safe as a tonsillectomy, from a mortality standpoint?
A Mortality is twice.
Q And what did you say it was as to an appendectomy?
A One hundred.
Q And in the case of a tonsillectomy or an appendectomy, if that was a minor, wouldn't the physician get the parent's consent before performing either of those medical procedures?
A If possible, I should think. I don't do either of those.
Q Well, do you think they would wait at least 24 hours to obtain the parent's consent?
A Well, a tonsillectomy is certainly an elective procedure. Appendectomies are a little bit less so, and so I don't think that there would be any problem with delay for a [81] tonsillectomy. I'm not sure what -- there's no law that says that you would have to get parental consent if it were considered an acute appendix and the parents were not available, somebody could give it.

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[82] Q Does the abortion counselor, when they determine that the patient is a battered woman, automatically refer them to personal counseling?
A I'm sure they do.

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[83] Q Now, is my understanding correct that you say the information in the written part, under consent for abortion on Page 11 of Plaintiff's Exhibit 6, is the base line of information as given to a woman?
A Yes, this is --

Q At Women's Health Services?
A That's right. This is read to the patient by the counselor, and then any questions that the patient may have are answered by the counselor. And then -- that forms the base, and then any other thing that the counselor feels is necessary to achieve informed consent is gone into it.
Q What if a woman asks about fetal development and asks, [84] like, what does the fetus look like, is she given answers to that?
A Yes, we have some pictures to show the patient what the--but we don't offer them, we don't display them in the wall or anything. They're in the counseling room, but they're not displayed and not every patient every needs to see them.

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Q And if the woman would ask about whether there's any agencies available should she want to carry the child to term, such as adoption agencies, does Women's Health Services answer those questions?
A Yes, they do, and they refer some patients to them. That's usually the job of the personal counselor.
Q All right. And if the woman asks about whether there [85] might be financial assistance benefits out there for her, do you try and refer her to the appropriate person to answer that question?
A Usually to a social service agency.

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[86] Q You also said that if the informed consent provisions go into effect that your colleagues might be deterred from performing abortions, is that correct?
A Well, we've had some discussions about this --

Q Well, yes or no?
A Yes.
[87] Q And that's based upon your discussions with your colleagues?
A That's right, when they were expressing concern about the act and what effect it might have upon them, and were particularly concerned about the criminal charges to be levied under the act. And it became more difficult for us to maintain adequate physician supply at Women's Health Services.

MS. MERSHIMER: Your Honor. I renew my objection that this is hearsay, and I would ask that Dr. Allen's testimony on how the act would deter or not deter his colleagues be stricken.

THE COURT: Overruled. I think we're not interested in the truth of this, but merely whether these conversations took place; overruled.

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Q Do you agree, Dr. Allen, that it's essential to the psychological and physical well being of a woman considering [88] abortion that she receive complete and accurate information on all options available to her in dealing with her unwanted pregnancy?
A Only if she hasn't already reached a decision.
Q Well, to reach a decision she needs to have information available to her, doesn't she?
A Yes, and we try to provide that, but I don't know . . .
Q All right. Now, when a woman comes in with an unwanted pregnancy, you said she could be under heightened stress or anxiety, is that correct?
A I said that the decision-making process is usually fairly stressful for the women -- woman.
Q And is that for the various reasons such as that she just realized she's pregnant, she's going to have to make

a quick decision about whether she wants to carry the child to term?
A It's not a physiological stress, it's a psychological stress. And it's usually a very difficult decision for a woman to make unless she has, prior to becoming pregnant, made a decision that abortion would be a backup for her contraceptive method, if it failed.
Q Would you agree that for a woman deciding whether to have an abortion that she should look at her individual circumstances, be provided complete and accurate information, and then have sufficient time for deliberation?
A Yes, and most of that has taken place prior to her coming [89] into the clinic.
Q And wouldn't you agree that as good crisis pregnancy counseling dictates that a woman be presented information in a non-directive manner, with sufficient information on all options, to insure that her decision as how to deal with her pregnancy is an intelligent, knowing and voluntary one?
A I don't know about intelligent, I would certainly agree with the voluntary.

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BY MR. ZEMAITIS:
[90] Q Dr. Allen, in your experience, is the informed consent dialogue different for each patient?
A It is different, yes.

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[91] MS. KOLBERT: Your Honor, Dr. Michael Alan Grodin is a pediatrician and a professor with over 11 years of experience in the field of medical ethics. Presently, Dr. Grodin is the Associate Director of the

Law, Medicine and Ethics program, and Director of Medical Ethics at Boston University Schools of Medicine and Public Health, where he is also an Associate Professor of health law, pediatrics and social medical sciences and community medicine.

In addition, he is an adjunct Associate Professor of philosophy in the College of Liberal Arts at Boston University. Dr. Grodin is a medical ethicist and human studies chairman for the Department of Health and Hospitals [92] of the City of Boston, and serves on the Board of Directors of Public Responsibility in Medicine and Research, and the American Society of Law and Medicine. He is also a member of the National Committees on Bioethics of the American Academy of Pediatrics, and serves on the National Committee on Ethics of the American College of Obstetricians and Gynecologists.

Following completion of his B.S. degree at the Massachusetts Institute of Technology and his M.D. degree at Albert Einstein College of Medicine, Dr. Grodin performed his post-doctoral and fellowship training at UCLA and Harvard. He has been on the faculty of Boston University since 1979.

Dr. Grodin has served as medical ethics reviewer for the *New England Journal of Medicine* and Oxford University Press, as well as other respected medical journals. Dr. Grodin has also delivered hundreds of addresses, is editing two books, and has authored or co-authored over 35 articles in chapters in books and professional journals, in the area of moral dilemmas in medicine and problematic decision making in clinical health.

DIRECT EXAMINATION

BY MS. KOLBERT:

Q Dr. Grodin, do you have a particular area of expertise in medical ethics?

A Yes, I primarily focus on the beginnings and ends of life, and ethical dilemmas surrounding those two periods.

[93] Q When you say the beginnings and ends of life, does that include pregnancy?

A Includes pregnancy, reproductive issues, abortion, new reproductive technologies, perinatal, neonatal issues.

Q Now, I told the Court that you are on the National Committee on Ethics for the American College of Obstetricians and Gynecologists, can you explain to the Court what your job responsibilities are there?

A The American College of Obstetricians and Gynecologists, which is a national organization association of board certified obstetricians and gynecologists, have several committees. One of the committees they have is called the Committee on Ethics, and that committee at a national level deals with policy implications surrounding questions that either the membership of the college and/or its administration seek to have elucidation on, illumination on. And the college's Committee on Ethics therefore studies these problems and gives statements -- issues statements on what the position, or what a reasonable position might be with regard to various issues, whatever the college wishes to ask us.

Q And I also understand you're on the National Committee on Bioethics for the American Academy of Pediatrics, what are the job responsibilities for that?

A The Committee on Ethics for the Academy of Pediatrics is [94] a parallel organizations for that group. As opposed to the College of Obstetricians, the Academy of Pediatrics is a national organization of board certified pediatricians who deal with issues of practice and policy, as well as children's issues. And they also have various committees, one of those being the Committee on Bioethics of the American Academy. And I sit on the national committee, which deals again with policy issues,

recommendations, concerns, whatever the administration and/or pediatricians should wish us to look at.
Q In your writings, professional activities and as a physician have you had an occasion to provide informed consent?
A Yes, I have.
Q And have you studied the doctrine and principle of informed consent?
A Yes, extensively.
Q Have you reviewed the literature taught and lectured on both the doctrine and the principle of informed consent?
A Yes.
Q And in your capacity-- can you explain for the Court that-- you are the medical ethicist, as I understand it, of the Department of Health and Hospitals for the City of Boston, can you explain for the Court the job responsibilities there?
[95] A Right. That is the clinical component of my job, as opposed to my academic responsibilities. That clinical responsibility is that I am the official medical ethicist for the Department of Health and Hospitals for the city, which includes not only the Public Health Department, but Boston City Hospital, which is a major municipal hospital in the City of Boston, as well as two other hospitals, chronic care hospitals. And in that capacity I am asked to not only educate and not only create policies for the Department of Health and Hospitals, but to do specific clinical consultations on patient care problems at the bed side, in the intensive care units, wherever they may ask me to come and consult and help them try to understand, illuminate and come to some conclusions about difficult moral and ethical dilemmas regarding patient care.
Q Approximately how many patients do you consult with in that capacity per year?

A I would say on the average maybe 50 or 60.
Q And can you explain for the Court your job responsibilities in teaching at Boston University?
A I am a professor of philosophy in the College of Liberal Arts, where I teach undergraduate and graduate doctoral students medical ethics and philosophy of medicine; I'm a professor of health law in the School of Public Health, where I teach ethical issues in medicine, public policy and public [96] health; and I'm a professor in the School of Medicine in the social and behavioral sciences -- socio-medical sciences and community medicine, where I direct the program of medical ethics and teach medical students at the undergraduate, graduate and post-doctoral level, as well as faculty.

MS. KOLBERT: Your Honor, at this time I would move the Dr. Grodin be certified as an expert on the question of medical ethics.

THE COURT: Any objection or any questions?

MS. MERSHIMER: No questions and no objections.

THE COURT: Motion granted.

MS. KOLBERT: Thank you, your Honor.

BY MS. KOLBERT:
Q Dr. Grodin, can you explain what is informed consent?
A Informed consent is both a procedural and substantive concept, which relates to the notion of a specific act that a patient in this case might wish -- be approached with a specific act and it relates to giving information, and having a discourse and dialogue with that individual, so that they understand various elements of choice, what choice they're going to have and what the elements of that choice are; and then ultimately, in a voluntary, competent manner, consenting to that act.
Q Is there a difference between the- principle of informed consent and the doctrine of informed consent?

[97] A Yes. As I understand those two concepts, the doctrine of informed consent would be a legal concept, which would be viewed in the legal legislature or by courts, whereas the principle of informed consent is a philosophical moral-ethical notion, which relates to the notion of respect for persons and autonomy and various ethical concepts which would be derived independent, for instance, of a law being in existence. So the principle of informed consent is a philosophical or ethical notion, and the doctrine of informed consent would be the legal embodiment, perhaps, of that ethical notion, or whatever the law says the doctrine of informed consent might be.

* * *

[98] Q What are the standards of this ethical informed consent?
A Well, there are several elements, first of all, to informed, voluntary consent. The first notion would be that it's free and uncoerced, meaning that it's voluntary. And the other notion would be that it is consent or competent, meaning that the person has the capacity, the mental capacity, if you will, to understand what they're being asked and what the elements of the informed consent process are.

More specifically, the question of standard would come up within the concept of what the information need be [99] transferred in getting this voluntary informed consent. And contemporary ethical discourse on this subject has suggested that the standard, meaning what information needs to be transferred in this doctor-patient relationship in the consent process, first of all is not an objective standard, meaning that the information that be transferred in an ethical sense should not be dictate purely by the physician. It seems to me that if in fact informed consent is to be grounded in

autonomy, giving people the right and the information they need to make decisions, than it's for the patient's needs that the informed consent process has occurred.

Therefore, the information should not be objectively what physicians think. If all physicians got together and decided that no information should be given, it seems to me that shouldn't be the standard, it should be what patients need. So that is not an objective standard, the standard--
Q Am I correct in saying that your testimony is the standards go to voluntariness and that they go to the subjective needs of the particular patient?
A Correct. So, insofar as informed consent is for patients, not for doctors, they're the ones that are being asked to have a certain action and to consent to it, the consent doctrine is set up for the needs and to create the autonomous situation, so that an empowered person can make a [100] decision.

Then the question would be, what is the content of that subjective information. And the modern, contemporary view of informed consent, from an ethical standpoint, would be that of course it is the patient's needs, but it is more than just what a generic patient would need, it is in fact what that individual, unique patient would need, because that's the person who is need of the respect that will cause them to be autonomously making the decision that they alone will need to make. So --
Q So are you saying then that the -- let me ask this, does that mean that informed consent varies from patient to patient?
A Absolutely.
Q What is the problem with content-based notion of informed consent?
A As I understand your question of content-based, meaning that there would be a specific direction as to

what information need be said or need not be said, seems to me that that goes against this ethical concept that each individual patient needs to be taken on their own merits. And some of them will have the need for more information, and some of them will have the need for less information, depending on their own clinical circumstances. And therefore, the contemporary view of informed consent from an [101] ethical standpoint would be that you should not have specific content-based informed consent, that that needs to be determined in the context of the relationship of the individual patients needs and the doctor or professional who's involved in giving the information.

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[102] Q Now this morning, Dr. Grodin, there was a lot of talk about counseling and the informed consent dialogue. Is there, in your view, a difference between options counseling and the dialogue of informed consent as you've described it?
A Absolutely. And the distinction I would make is that informed consent can only be obtained in relationship to some action that need be taken, you are getting consent for an action, if you will. And that's quite different and, therefore, the standards of information and what have you relate to the notion of informed consent. Options counseling is just that, it's a discussion. There is no need for action at that point, it's basically discussing what the various options that are available and counseling, discussions around that. But that is quite different than asking for informed consent to a specific action. And therefore, usually, you would start off with options discussions and then move into informed consent for a specific action.

* * *

[103] Q Can informed consent ever be obtained over the telephone?
A I would say no.
Q Why not?
A Because as I've suggested informed consent is to a specific action, and you would need to understand not only that the person has been informed adequately, but that they are giving consent and that it's voluntary. And the concern I have, for instance, in obtaining consent is the voluntariness independent of being able to see the person, and to see how they react and understand and ask questions. How do I know, for instance, on the phone that somebody isn't holding a gun to the person's head and asking them to respond to the questions, there is no way to know that. So in the absence of actually coming face to face with the individual, I have a difficult understanding that they are giving their voluntary, if you will, uncoerced informed consent.

So there are many elements, not only the information that I would need, encounter and interaction to see about unsaid types of experiences and uncomfortableness and what [104] have you, but also the consent part. So I would need to make an assessment of competency, if you will, or capacity in a medical sense, which would require seeing the person. And then the voluntariness would be of great concern to me over the phone.
Q Can information be imparted over the telephone?
A Yes.
Q But that, in your view, is different from obtaining informed consent?
A Correct. By giving information, you're not asking for a specific action and consent to that.
Q Can informed consent be obtained through the use

of a tape-recorded message?
A No.
Q And how about through the use of printed materials?
A No. Those might be adjuncts, but consent could not be obtained.
Q During the informed consent dialogue, should a physician or counselor try to lead his patient to his or her preferred medical choice?
A No, the idea should be to lead the patient to what their choice is, not what the professional's choice is. Again, informed consent is for patients, not for doctors or counselors.
Q And is this true also with the informed consent dialogue [105] for abortions?
A Absolutely.
Q Now, you've said that the disclosure of information about the risks and the benefits of a particular medical procedure is the key to the ethical underpinnings of this principle, how extensive should that disclosure be?
A To the specifics of the information?
Q Mm-hmm.
A Again, that would depend on the individual clinical encounter, it would depend on the patient on their background, on their history of encounters with the medical system, on any one of a number of factors. And I would not be able to say specifically how much or how little, because it would depend on the clinical circumstance.
Q Can inappropriate disclosure, that is providing either too much information or not enough information ever be harmful to a patient?
A Absolutely. First of all, insufficient information would not give them perhaps the elements that they need to make that informed, knowledgeable, free, uncoerced, voluntary consent; and giving them more information than they need might cause them to be unnecessarily

confused, cause stress, cause anxiety, cause them to misunderstood in fact what the nature of the relationship is. So it would depend on how much more information and what the context of that [106] information was, as it would depend on how little information and what the context of that little information was.
Q Do you have a view on whether or not inappropriate disclosure can be harmful to the doctor-patient relationship?
A Absolutely. Again, if in fact the physician is giving what we call inappropriate information, meaning information that they don't feel is necessary in the doctor-patient relationship, it would confuse the physician in terms of understanding what the goal of the relationship is and try to figure out what the limits and extent of the informed consent process are, which as I said needs to be individualized. So it seems to me that it would cause confusion equally, confusion, problems, anxiety and concerns for the physician for not knowing -- not being in control of the mutual participation between the physician and the patient in this consent process.

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[107] Q Dr. Grodin, do you have an opinion about the provisions of this act and whether or not it may cause physicians -- or will cause physicians to violate ethical standards in providing informed consent?
A This act as written, or as I understand it to be written, is specifically content-based. Meaning that it directs physicians to give, or maybe even not give, depending on how you read it, certain information to patients, which again would stipulate what the nature of the patient's need is. And as I have said before, the patient's need has to be assessed on an individual basis. And therefore, this is a content-based notion of informed

consent, which is not what I think is the present contemporary standard of what informed consent should be.

Q Now, I direct your attention to Subsection l(i) in Section 3205, which appears on Page 8 of the document before you, which states that the nature of the proposed procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo the abortion must be given to the patient.

A Right.

Q Do you have an opinion about whether or not that standard is appropriate?

A I would again note that I think it's not a reasonable patient that's the relevant issue here, but rather the [108] specific patient. And there may be patients, for instance, who are quite unreasonable, that they want a lot more information than what a reasonable patient would want, or there may be specific patients who want less information or need less information. And therefore, again, it seems to me that you don't want to stipulate even in what is a standard, which is most people would want to discuss the risks, benefits and alternatives. As to what the content of that might be, it seems to me that the standard should be the individual patient, not necessarily what a generic -- if I even knew, reasonable patient might need. So the materiality, it seems to me, goes to-- you can't materiality outside of an individual patient.

Q I direct your attention to Subsection 3(i), which is directly below, which requires the physician to provide the medical risks associated with carrying her child to term; do you have an opinion about whether or not that standard is appropriate and consistent with current medical practice?

A I would again make the notion that this is a content-based directive, which I think is inappropriate in

and of itself, because you would need to deal with the specific patients. It's particularly problematic though in the content of an abortion consent, because it seems to me that if in fact the patient has already made a decision based on the option discussion and now we're into the informed consent [109] part, that it is not relevant to be going into informed consent around issues that are unrelated to the action that the patient is there to give consent for. So, it seems to me that it's immaterial and not relevant.

Q Now, are you saying that the woman never should have information concerning the risks of carrying the pregnancy to term?

A Oh, of course not. But if a patient came to your obstetrics office and was going to carry a pregnancy to term, as an example, and that was her decision, it would seem equally inappropriate to say what the risks of an abortion are if she's coming to your clinic to be talking about pregnancy and carrying a pregnancy to term. And therefore, again, I would say on either side the issue is the appropriateness of the information in relationship to the specific consent that's being obtained around the specific action that the patient is being asked.

Q I direct your attention to Subsection 2(i), which requires that prior to an abortion a physician or a qualified physician assistant, health practitioner, technician or social worker provide or offer to the pregnant woman information that the department publishes, printed materials which describe the unborn child and list agencies which offer alternatives to an abortion; do you have an opinion about whether or not this section comports with medical evidence?

[110] A Not only do I think it inappropriate to have content-based consent, but it seems to me that to go beyond that and once you've decided that there's content-based need for bringing up information, to give

specific information that's generic for all parties seems to me inappropriate because that may not be the needs of that individual patient.

Q I direct your attention to Subsection 2(ii), which requires the provision of information involving medical assistance benefits that may be available for prenatal care, child birth, neonatal care, and the availability of that assistance; do you have an opinion about whether or not that particular subsection comports with medical evidence?

A Again I believe it's content-based, therefore problematic. But insofar as the information, it does not say whether in fact there is or isn't benefits, it seems to me it's confusing even at that level. It may or may not be the case, in fact, that there is or is not medical assistance available and, therefore, that doesn't say very much. And it also seems to be problematic for the physician to know whether in fact there may be medical care available, depending on where one lives and what the availability is of obstetrical care or of pediatric care, or what have you. It depends on what one means by available.

Q I direct your attention to Subsection 3(i), and ask you whether or not you have an opinion about the medical ethics [111] of providing information that the father of the unborn child is liable to assist in the support of the child?

A Again, it seems to me that that is information that's beyond the expertise of a physician to know whether a father is or is not liable, it seems to me that that's a legal question that is not for a physician or clinician to be discussing. Even if it be true, I might add, it seems to me that that's beyond the expertise of a physician, any more so than a lawyer giving medical information.

Q Now, if you take these sections together, from Subsection 2 and Subsection 1, little 3, that is the

information involving carrying the pregnancy to term, do you have an opinion about whether or not those aspects of the content-based informed consent will change the dialogue and, if so, in what way?

A Again, it seems to me that it dictates and intrudes on the standard, the notion of doctor-patient relationship in this material, individual-based notion of informed consent, because it dictates what will or will not occur. And, therefore, may in fact cause conflict between what the physician and/or patient needs or wants are, and at minimum might confuse what the outcome or what the importance is, what the goal is of that relationship, which is to have a patient informed.

* * *

[112] Q Dr. Grodin, I'm going to show you what has been marked as Defendant's Exhibit 49. I'd like, if you could, to take a look at that exhibit for me.

(Pause.)

Q And could you identify it for us?

[113] A It's dated January, 1990, and entitled Attachment Number 2, Directory of Social Service Organizations, and there are listing with addresses and phone numbers of a number of organizations in various counties in Pennsylvania, with also numbers under special services, and those numbers I believe refer to another document -- I presume refer to another document that list what those special services are or might be.

Q Dr. Grodin, do you have an opinion about whether or not it is appropriate as a matter of medical ethics to offer this type of information as part of the informed consent dialogue?

A Again, clearly not as part of the informed consent dialogue, because the informed consent is to an action and it seems to me that at that point we're talking about

the informed consent around an abortion, if that's the situation. So clearly it is not appropriate as part of the informed consent part of the dialogue.

Q Now, if some of these agencies listed in this document are agencies that provide services to pregnant, and may or may not be religiously based organizations, do you again have an opinion about whether or not it is inappropriate for doctors to offer this information as a part of the informed consent dialogue?

A Not as a part of the informed consent dialogue.

* * *

[114] Q Could you identify Defendant's Exhibit 51 for us?

A It is a one-page sheet with a number H520.705P, called the Commonwealth of Pennsylvania Department of Health Notices Required by Abortion Control Act, July, 1990.

Q Have you had an opportunity to review this document?

A Yes.

Q Do you have an opinion about whether this document and the notices that are listed therein are consistent with contemporary medical ethics?

A Again, this is a content-based document which specifically directs information to be given, which may or may not be appropriate, depending on the individual needs of an individual patient with the doctor-patient relationship in that clinical circumstance.

* * *

Q Within Subsection C, that begins on Page 9 and ends on Page 10, there is a provision that says that no physician [115] shall be guilty of violating this section for failure to furnish information if he or she can

demonstrate by a preponderance of the evidence that he or she reasonably believed that furnishing the information would have resulted in a severely adverse effect on the physical or mental health of the patient -- are you with me here?

A Yes.

Q Do you have an opinion about whether -- first of all, what-- what --

A That is often called in medical ethics parlance of therapeutic privilege, as well be in the legal, which means that in certain situations, and it is usually related to a specific case and a specific time, or a specific concern is brought up that giving certain information that the physician might otherwise think would be material to that individual person, or they might not give that information because of concern, for instance, about someone committing suicide or having some other serious reaction to the information in the context of informed consent.

Q Do you have an opinion about whether or not this particular therapeutic privilege comports with medical ethics?

A The problem I have with this notion of therapeutic privilege is that it's in the context of a content-based notion of informed consent. If in fact one follows the [116] contemporary view of medical ethics in terms of informed consent, which is that one goes to the material needs of an individual patient at that specific time with the specific concerns and materiality of that individual patient, then it seems to me one doesn't need to invoke the notion of therapeutic privilege very often unless there happens to be a specific situation, again, with a very serious concern that something will happen in the material base of what information you thought should be transferred. But in the context of this statute, it seems to me that you might want to or need to invoke this quite a

bit, because it's a general statute saying that all reasonable would need certain information and for that specific individual you might make the assessment that they need less information than what's in this. And therefore, you have to, if you will, invoke this therapeutic privilege more than, I would think, as the standard notion of therapeutic privilege, which is it should be invoked very, very rarely, if at all.

Q Do you have a -- within the circumstance that a physician was following this statute as outlined, do you have an opinion as to this particular therapeutic privilege, let's assume for a minute that this informed consent were applied?

A Then I would have concern about what the word severely means.

Q And what's that concern?

[117] A I don't know what it means. I'm not sure severely adverse effect would mean vis-a-vis a specific patient, outside of the context of that individual patient.

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Q I refer your attention to Subsection D, which is the limitation on civil liability, are you familiar with this subsection?

A Yes.

Q Do you have an opinion about whether or not this subsection comports with medical ethics?

A Yes.

Q And what is that opinion?

A I feel that no statute should make physicians immune for liability, no statute should make physicians immune from liability for meeting specific content-based informed consent. Again, as I said, if a patient needs more or less information to make an informed, empowered, autonomous decision, then that's the information that

they should have. And I would be quite disturbed by the notion that a physician is immune from liability for meeting just the minimum standard that for instance is set up in this statute, when in fact the patient may need much more information or much less information. And therefore, I have a problem with, [118] statutorily, making a physician immune from liability based on specific content-based information.

Q Now, Dr. Grodin, this Section 3205 also requires that a physician wait for 24 hours from the time that he or she obtains informed consent until the abortion is performed; do you have an opinion about the medical ethics of this 24-hour waiting period?

A Again, it seems to me that that is a content-based notion of informed consent that in some circumstances that may be appropriate for individual patients and in some circumstances it may not be appropriate. And therefore, it seems to me that you should not have a generic statement for all reasonable persons, if you will, because again some people may in fact not need or not want that amount of time, or may in fact need or want more time than that.

Q Are you aware of any other area of medical decision making which would have a similar 24-hour waiting period.

A Not to my knowledge.

Q Section 3208 of the act, which begins on Page 18, requires that the physician, as part of the informed consent dialogue, offer materials which are those which I have shown to you, do you -- this merely requires the physician to offer those materials, do you have an opinion as to whether or not that would violate your standards of professional ethics?

A Again, in the context of informed consent, which is what [119] I understand this to be about, it is consent to a specific action. And therefore, it seems to me

inappropriate to even offer, as an example, material that is irrelevant to the specific action that the person is being asked. As an example, if I were a patient that had discussed with my I family or with physicians or nurses whether I should have gallbladder surgery and have my gallbladder, by either surgery or by medical therapy, as an example, and then I've come to a conclusion over time that I want to have surgical procedure and I don't want to live with taking medicine any more, I want to have my gallbladder taken out, I've now come in to get consent for the gallbladder surgery. It seems to me inappropriate to say but, you know that I could give you information about medical therapy, when in fact the patient has already thought about that and now is coming in for a specific consent related to a specific action, which is a surgical procedure.

Q Do you have an opinion about whether or not offering pictures at two-week gestational increments of the fetus would violate medical ethics?

A Again, the same situation. I would not offer routinely information, that I would have to depend on individual patient for their individual needs. And then it seems to me that occurs in the option-based part of the two-part option counseling in informed consent approach to patient care. So [120] I don't have a problem specifically with pictures, if in fact that's what the patient needs and wants and asks for.

Q Now, you've testified in a number of different instances that the act as currently drafted would violate professional ethics. What's the effect on a physician who is required to provide this information which in your view would violate those professional standards?

A Well, it seems to me it may have many effects, not the least of which is to cause them to be confused and can cause them to not understand what the goal -- who the informed consent process is for; is it for patients, is it

physicians, is it for hospitals, is it for legislatures, what is the goal and intent? So that would be confusing and, again, problematic. If in fact the physician were to act on what they felt was the present standard of ethics and it was contrary, for instance, to what the law said, that would cause increased stress, not just confusion, but stress as to what one should do. Whether one should in fact follow what one believes or thinks the law is, if one can understand it, or what their medical ethics and their profession dictates to them. That would cause stress over time, which would be detrimental to their patient care as well as to them. More specifically, over time, many people will not want to place themselves in that type of situation and, therefore, they will stop doing whatever it is that is constantly placing [121] them in a situation where they have to act differently than what someone is telling to do.

Q In your view, would that mean the physician would stop performing abortions?

A I believe some would.

Q Dr. Grodin, I'd like to give you a hypothetical situation that is based on facts that will be presented in evidence in this trial. I want you to assume that you are a physician providing abortion services and that into your office comes a woman who has been battered and that you suspect that this woman has, from her injuries and her demeanor, that she has been battered, and you offered that woman assistance for the underlying problem of battering, but that woman refuses the assistance because she does not consider herself a battered woman. Similarly, you have a suspicion that informing that woman's husband of her pregnancy will lead to danger to her and may well place her in a life-threatening situation, do you have an opinion -- let me say one more fact, which is that the battered woman would be unwilling to declare herself battered under the

exception to Section 3209 of the act, that is she is unwilling to sign a statement that she considers herself to be at a risk of bodily harm as a result of notification. Do you have an opinion about what, if anything, the physician should do as a matter of medical ethics in that circumstance?

[122] A First and foremost, the physician's obligation is to meet the needs of the patient and to try to speak to their welfare and their beneficence, to benefit them. And therefore, it is clear that the information should not be passed on to her spouse, in that it would cause -- there is good reason to believe that it would cause her to have significant harm.

Q What, if anything, is your opinion about how the physician would make that event occur if the act requires him to -- or requires either a statement from the woman that she's notified her spouse or has exempted herself from the act's coverage?

A Well, again, the physician clearly cannot reveal the information because that would cause harm to the patient, according to the ethical principles of beneficence and patient, doctor-patient relationship and care. Therefore one would have to do, it seems to me, one of two things: either have the pers-- encourage the woman, if you will, to lie and say that she has informed the husband if she hasn't, which I understand might have some significance for her in terms of the statute, and/or the physician would have to certify that according to the statute there will be -- there are extenuating circumstances that require one not to pass on the information which apparently this doesn't meet.

So either the physician would have to take on the responsibility of disobeying the statute or the patient [123] would, it seems to me, but one of those two things would have to be done because one thing that clearly should not be done from a moral standpoint is to pass

the information on to a spouse who you have reason to believe will harm this woman.

Q Now, I would like to give you a second hypothetical that involves a woman who has been a victim of marital rape, that is, she's been raped by her spouse. And under Section 3209, prior to the performance of an abortion, the woman would either have to notify her spouse or again sign an affidavit that her spouse -- I'm sorry, that the pregnancy is a result of spousal sexual assault which has been reported to law enforcement agency having the requisite jurisdiction.

Now, assuming this circumstance that a woman comes forward to you, says she is a victim of marital rape, the pregnancy is a result of that marital rape but that for a variety of reasons she refuses to initiate criminal activity criminal prosecution against her husband and refuses to report to a law enforcement agency having the requisite jurisdiction, do you have an opinion about what if anything the physician should do as a matter of medical ethics in the circumstances?

A My concern again would be to the welfare of that individual patient who in fact I have developed a relationship with and my goal is to try to beneficently care for them and to give them the care that's necessary and [124] appropriate and to their best interests. And therefore insofar as I would have deep concern of passing that information on to a spouse which she says that that will cause her harm and I have every reason to believe it will, I would not pass that information on.

Q And again do you have an opinion about what the likely effect is on the doctor to avoid the requirement of the act?

A The doctor then to follow what is the ethical appropriate course of action in the nature of doctor-patient relationship then would either have to ask the patient to violate the statute and/or would have to

violate it themselves.

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Q I'm sorry, let me strike that. I would ask you to turn to Page -- it's Section 3206 of the act which is the parental consent division, and that begins on Page 10.
A Mm-hmm.
Q Are you familiar with this provision?
A Yes.
Q Do you have an opinion on whether or not this provision comports with medical ethics?
A As I understand the provision it requires the informed consent of both the parent and the child. Insofar as medical [125] ethics deals with informed consent in an individual person, one cannot get informed consent from two parties. Either the person is competent and has the capacity to do a voluntary informed consent and therefore they will consent and/or they're incompetent and therefore a proxy or surrogate is the one who is making the informed consent. There is no place in medical ethics, as far as I know, where you could ask two people to give an informed consent for a specific action. It is incompatible with the notion of a doctor's informed consent which again relates to an individual person's needs and a specific action that an individual person is going to, so either someone gives informed consent themselves or they are unable to and someone else must be a surrogate or proxy for them to give that informed consent.
Q Now, Dr. Grodin, were you in the courtroom this morning when Dr. Davidson testified?
A Yes.
Q And did you have an opportunity to hear his testimony?
A Yes.

Q As I recall the testimony -- and you may correct me if I'm wrong -- he testified that in his view in certain circumstances there was a possibility that the act, if applied, the definition of medical emergency if applied to certain circumstances would cause him to change his manner of medical care and violate what he termed his ethical [126] obligations. Do you have an opinion about the ethics and the dilemma that Dr. Davidson would be faced when having to apply the definition of medical emergency as contained by the act?
A Again, I feel that physicians' obligation are to patients, first and foremost, and that should be their concern which is meeting the needs of patients and trying to, particularly in an emergency situation, deal with those particular problems and therefore it causes me great distress to think that an emergency room physician might be worried about statutory definitions, legal counsels or anything else when, in fact, someone comes in with an emergency situation and they are called upon to act to the best of their medical judgment dealing with a particular medical circumstance.

So I am quite concerned about an emergency physician who says that there is a conflict or that they think about it or in fact they have to do something different than what they think the law dictates for them which will cause stress, anxiety, maybe change in the way they practice maybe for them to be less certain about how they should proceed or have other concerns. The primary if not sole concern should always be trying to meet the best interests of a patient.

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BY MS. MERSHIMER:
[127] Q And the therapeutic privilege that you were talking about, that applies to the physician in the doctor-patient relationship, is that correct?

A I'm sorry, I don't understand.
Q The therapeutic privilege that you had described, you said was contained in Section 3205(C), do you know what I'm talking about?
A I do.
Q And that applies to the physician in the doctor-patient relationship?
A As I understand it, yes.

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[129] Q All right, well, can you think of any circumstances other than the suicide example where therapeutic privilege would apply in an abortion context?
A Ask the question again, please?
Q Can you, when I asked you can you give me any examples other than the suicide example you gave where the therapeutic privilege would apply in abortion cases, you said "I can't think of many." I'm asking you for any.
A Well, again, if in fact the patient were going to -- if you had reason to believe that they would have severe depression and go into a severe depressive state and that [130] based on their psychiatric history, many of these things relate to psychiatric types of problems, but it seems to me that those are the types of situations where generally the therapeutic privilege might be invoked or where somebody would cause harm to themselves or to others based on the information being disclosed. But it seems to me that should occur quite rarely, I would hope. That's what the notion of the therapeutic privilege is because again you're giving -- you're not giving information that you believe the patient needs and is material; that's critical.
Q We've been going through some sections, 3205(A)(1)(3), and also Sections 3205(2) and all the provisions under that and you gave your opinion that you

had a problem with all those requirements under the informed -- as being information provided by informed consent, is that correct?
A Correct.
Q Now, if the Commonwealth took it out of the caption of being informed consent and just required it as additional information that had to be provided sometime before the abortion then you don't have the same ethical problem?
A That's a different question.
Q Well, I'm asking you.
A Could you ask me a question?
Q If the Commonwealth would take out the requirements that are listed in Section 3205(A)(1)(3) and all the provisions in [131] 3205(A)(2) and they take it out of being under informed consent but would make it a separate requirement that documents or information be available to a woman before she had her abortion, would you have the same ethical dilemma?
A I would still have problems with specific content directed information, even in the counseling setting, although I'm much more open to the notion of presenting lots of different information than the -- that are unrelated to the specific action of informed consent, I have problems with any content based specific information that all people need receive in all situations because individual people have individual needs and therefore some people need more and some people need less information.
Q So if any state enacted any informed consent provision that had content based requirements, that's no good ethically to you?
A My, again, sense is that the contemporary view of medical ethics is that we should try to meet the individual needs of the individual patient and therefore to direct medical care through the legislature or through

law or anything else is inappropriate.
Q The requirements under Section 3205(A)(1)(iii) talking about the nature of the proposed procedure and treatment and of those risks and alternatives to the procedure or treatment that a reasonable patient would consider material to the [132] decision of whether or not to undergo the abortion, that shouldn't be required as part of informed consent?
A Again, the infor-- what I would say is that the information about the risks, benefits and alternatives, that that specific patient needs is what should be given.
Q So the statute would be all right if it just took out reasonable patient to the specific patient?
A I -- yes.

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[135] Q When you were given the hypothetical about the battered woman and you said there was a choice between either the patient disobeying a law such as lying on the form or else the physician disobeying the law by going ahead and performing the abortion without having the notice being given, isn't another option is to encourage the woman to check off the box saying that she fears physical violence and guaranteeing her confidentiality and try to get her some help?
A Well, absolutely. But as the case was presented to me, she refused. Obviously you would want to discuss why it is that she's fearful, explain that checking off this box would mean that we wouldn't have to pass on the information, et cetera, et cetera, et cetera, but as the case was presented me in no uncertain terms even after persuasive discussion, not just, you know, open discourse, but in fact encouraging [136] and persuading which I think would be in the realm of what an appropriate doctor-patient relationship would be, if she absolutely

refuses, then you have only a few options available. The other one perhaps would be to question her competence or capacity, but I think that that was not as the case was presented. If in the context of that she also relates psychiatric symptoms or what have you or is delusional or what have you, then there might be other modes to go down, but it seems to me that as the case was presented, that's the only option available. In fact, it may be part of her disease or battering that she's unable to sign off on that, but that's a little bit outside of my expertise, but I have in my clinical encounter dealing with child abuse found parents that will not be able to admit and up front say that they abuse their child, even though the child has physical evidence of abuse in front of you and that they clearly have abused the child, but they are unable to specifically say that they abuse their child because of concerns about their psychodynamics of intent, all kinds of issues. So --
Q All right, thank you, Doctor, I think I get the point. You would agree though it's a doctor's ethical obligation in such a case when he is presented with a battered woman to encourage her though to get help and get treatment?
A I'm sorry?
[137] Q You would agree --
A Oh, in terms of the battering?
Q Right.
A Oh, yes, absolutely I would say that there is a serious problem here and the fact that you won't sign this may be as much a part of the problem because it's recognizing, accepting there is a serious problem and I would encourage her to explore this.

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RONALD JOSEPH BOLOGNESE, Plaintiff's Witness, Sworn.

THE AUDIO OPERATOR: State and spell your name for the record, please?

THE WITNESS: My first name is Ronald, R-o-n-a-l-d, middle name Joseph, J-o-s-e-p-h, last name Bolognese, B-o-l-o-g-n-e-s-e.

MR. ZEMAITIS: Your Honor, Dr. Bolognese will be [138] tendered as an expert in the practice of obstetrics and gynecology in Pennsylvania and in particular the practice of perinatal medicine.

Dr. Bolognese received his Bachelor's degree from Princeton University in 1959 and his M.D. from the University of Pennsylvania School of Medicine in 1963. After graduating from Penn, he served rotating internship at Bryn Mawr Hospital in Bryn Mawr, Pennsylvania, and he served as a resident in obstetrics and gynecology at Pennsylvania Hospital, also in Philadelphia.

He is licensed to practice medicine in Pennsylvania and New Jersey and he has specialty certifications from the American Board of Obstetrics and Gynecology in 1969 and the Internal Fetal Medicine Board, which is a division of ACOG in 1974.

He has served on the faculty of the School of Medicine at the University of Pennsylvania, serving as a Clinical Assistant Professor of Obstetrics and Gynecology, an Associate Professor of Obstetrics and Gynecology. He also serves as the Director of the section on Perinatology of the Department of Obstetrics and Gynecology at Pennsylvania Hospital and he has served as a Professor of Obstetrics and Gynecology at the University of Pennsylvania School of Medicine.

Since 1985 he has been Chairman of the Department of [139] Obstetrics and Gynecology at Pennsylvania Hospital.

DIRECT EXAMINATION

BY MR. ZEMAITIS:

Q Dr. Bolognese, could you describe for us the practice of perinatal medicine?

A In 1974, the early 1970's actually, the American College of OB/GYN determined that there were subspecialty areas that required additional training and expertise. One of those was maternal fetal medicine or more loosely referred to as high risk obstetrics. And the purpose was to produce a group of physicians who had the expertise in the identification of patients who had less than an ideal chance of a successful outcome of pregnancy due to either maternal complications, medical complications that the mother brought into the pregnancy such as diabetes, hypertension, or complications that arose in her previous pregnancies such as premature labor, neonatal demise, stillbirths, that tend to repeat during subsequent pregnancies. So then in general the patient was at significant risk for a poor outcome in a subsequent pregnancy.

Q Is perinatology now recognized as a specialty in the obstetric and gynecological practice?

A Yes, in 1974 the American College of OB/GYN established the subspecialty and I was one of the original 14 physicians boarded in maternal fetal medicine at that time.

[140] Q What was the qualification process that you had to go through to become qualified?

A The initial process was a grandfathering of the physicians who had a level of expertise. To prove that, they submitted a series of cases over a two or three-year period, identifying the types of complications, the types of patients that they cared for, and this was judged by senior members of the American College that these physicians indeed had an expertise and a familiarity with the process of complicated obstetrics.

They were then asked to submit a thesis on published material for approval by the board and at that point subjected to a intense oral examination for the completion of the process.

Q Since your qualification has your practice been a specialty practice in perinatology?

A Yes, it has.

Q Now, as I mentioned a few moments ago, you have some teaching responsibilities both at the University of Pennsylvania and at Pennsylvania Hospital. Could you describe the teaching responsibilities you have?

A Pennsylvania Hospital is the major affiliate of the University of Pennsylvania and well over half of the students who choose obstetrics and gynecology as their course are trained at Pennsylvania Hospital as part of the rotation. [141] And I participate in a lecture course and daily rounds with the medical students. In addition to that, we train 20 residents at any given time in obstetrics and gynecology at Pennsylvania Hospital and I'm responsible for some of the teaching of those residents. And, lastly, we have a fellowship in maternal fetal medicine. At any given time we have four fellows who are a part of our program and I play an integral part in training those fellows who will go on to be perinatal specialists around the country.

MR. ZEMAITIS: Your Honor, we move that Dr. Bolognese be qualified as an expert in the practice of obstetrics and gynecology in Pennsylvania and in the practice of perinatal medicine.

THE COURT: Any objection or any questions concerning qualifications?

MS. MERSHIMER: No, your Honor.

THE COURT: Motion granted. Shall we proceed?

MR. ZEMAITIS: Yes, your Honor.

BY MR. ZEMAITIS:

Q Dr. Bolognese, could you get in front of you, I think

it's the document you have right there, it's the Abortion Control Act and I would ask you to turn to Page 5 on which is contained the definition of medical emergency.

Have you had an opportunity to review that definition before your testimony here today?

[142] A Yes, I have.

Q Knowing the problems you encountered in your practice of perinatal medicine, how do you react to that definition as it would apply to that practice?

A It's a vague and confusing definition that places the physician in, I think, a dilemma in trying to interpret the law as well as interpret the specific components and words as substantial and good faith clinical judgment, impairment of bodily function. The orthopedic service may not interpret the uterus as a major body function and I may not interpret the knee as a major body function, so that there are just a vague, confusing definition of medical emergency.

Q I'd like to point out some of the specific terms and ask your reaction to them: serious risk. Is serious risk standing alone a term that you use in your medical practice?

A Alone we would try to define that a little bit better than by serious risk. We'd specify indications or conditions that would be -- would statistically tend to point us in the direction of serious. Serious is such a vague term and it is not a medical term.

Q Is the term "substantial impairment" a term that you use in your medical practice?

A I'm not sure what a substantial impairment is. Is 75 percent impairment substantial? Is 50 percent substantial? Is 25 percent? Depending upon the body function, five [143] percent could well be substantial and other body functions, 90 percent may not be considered substantial. So again it's a very vague, imprecise term.

Q Now, the final term I'd like you to take a look at is

"major bodily function." Do you have any understanding as to what that term means?

A Again, as a physician, I can't think of many body functions that would not be considered major. Obviously as an obstetrician-gynecologist, I suspect that I focus on the pelvic organs as major body functions, but that position may not be agreed upon. Certainly women can live without major bodily functions of the uterus and the ovaries, but in our judgment, that certainly a loss of the uterus or ovaries would be a loss of a major body function. So it's very imprecise and again vague as to all the medical terminology.

Q If the statute goes into effect and this definition of medical emergency begins to apply to the practice of obstetrics, what do you predict obstatricians will do?

A Panic. I think the first reaction of most physicians would be to look at this law and decide that they just don't want to have anything to do with it. I think the advent of increasing legal action on the part of physicians has had a significant impact upon how they practice, and that's in a civil area. Physicians in general are not used to a criminal area, but they are typically concerned and afraid, so my [144] first reaction would be that the assumption of most physicians is just not get involved with this. The second reaction may well be to create another layer of committee or judgment so that the physician may seek advice or seek sharing the responsibility of the decision by going through some type of a committee or I could imagine myself as a chairman of a department of being placed in the position of judging each and every medical emergency because the physician does not want to take that responsibility totally upon his or her shoulders. So I think you create another either no action or another layer of bureaucratic administration to decide a medical judgment.

Q What consequences would those have on actual

treatment of patients in emergency situations?

A Well, I think it would confuse -- first of all, the patient would either be rejected of that treatment and time would be lost in finding another physician to assume responsibility or liability or whatever to care for the patient or to create the circumstance of time lost by committee meeting or time lost in finding a chairman of a department to make that decision.

As a chairman of a department, I might well choose not to be involved myself because of the criminal responsibility that I could assume by participating in that judgment, so I think it would cause delay, confusion, and the [145] person that would suffer, the persons that would suffer in that end would be the mother and potentially the fetus.

Q Now, are you aware that in the statute there is a 24-hour waiting period, mandatory waiting period between giving of the information for informed consent and the performance of an abortion?

A Yes, I am.

Q In your practice as an obstetrician, once a woman has given her informed consent to any medical procedure, is there any reason, any medical reason to delay that procedure?

A Generally not. There are some situations and it was in line with what Dr. Grodin was pointing out. There are occasional circumstances where the complexity of the judgment placed upon a couple does require some time on their part to arrive at a decision one way or another, but in most instances, if it's truly a medical emergency or a judgment or procedure, once we have provided adequate explanation and informed consent tailored to the patient, tailored to the understanding of the patient, there are very few circumstances that would justify a delay.

Q Can you think of any specific examples where you

think it might be to the patient's benefit to have some time between receiving the information and having the procedure?

A There are certain circumstances in genetic abnormalities, for example, one example would be a Kleinfelder's Syndrome, [146] the identification of a fetus that has the Kleinfelder's Syndrome. This is a child with an extra Y chromosome, this so-called super male. Data in the past used to imply that there was a higher percentage of criminal behavior on the part of this type of an individual and based upon the fact that examples or blood tests in criminal -- in institutions, prisons tended to demonstrate that. That data is of no validity today but the fetus may well be unusual in certain circumstances, this fetus will be sterile, the intellect of the fetus will tend to be as an adult on the average side rather than above average, but not retarded, so that there are some subtleties in that judgment where the fetus indeed may be quite normal as an adult, except for some limitations and does that couple want to take those choices.

That requires a little bit of time and thought on that couple's part, so that would be an example that I could see.

Q In your treatment of high risk patients, are the women that you treat typically trying to carry their pregnancy to term and have a child?

A That's the primary purpose for seeing us, yes.

Q Do you ever face situations where you have to terminate the pregnancy of one of your patients prematurely, even though the woman would like to continue the pregnancy?

A Yes.

[147] Q What are the most common conditions you encounter in your practice of that type?

A The most common would be premature ruptured membranes leading to infection. The second example

would be the development of a bleeding source, usually from a placenta that is prematurely separating, that chronically is causing a loss of blood to the mother and necessitating or beyond her ability to proceed with blood replacement. Or the development of preeclampsia which can go on to eclampsia and that so-called HELLP Syndrome, would be the three more common examples.

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Q Dr. Bolognese, I'd like to focus for a moment on the [148] situation where the woman has a ruptured membrane ultimately leading to infection. How frequently does that phenomenon occur in your patient population?

A Well, prematurity represents about six to ten percent of all births in the country, and about 25 to 30 percent of cases of premature delivery are proceeded by rupture of the membranes prematurely.

In our circumstance at Pennsylvania Hospital as a tertiary care center, because of the expertise of the perinatal service and because of the expertise of our neonatal care, we receive a number of transfers of patients who have prematurely ruptured membranes at outlying institutions and who are going to be cared for at Pennsylvania with the thought of either providing the maximum care for the mother or the ideal delivery route or the best possible care for the neonate at the time of the delivery.

So it is a -- represents, prematurity represents well over 50 to 60 percent of the complications we care for and so it represents about 25 to 30 percent of those complications, so it's a fairly frequent problem.

Q Does the problem of the ruptured membrane occur in women before the fetus is viable?

A Yes.

Q And it also occurs after, I take it?
A Yes.

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[149] Q I'd like to take a particular example of this and assume for the moment you have a patient for whom the membrane has ruptured, a membrane has ruptured, but there is no infection evident at this point in time. What would be the accepted course of management for that patient?
A Well, depending upon the point at which the rupture occurred in the gestation, we will advise the patient that if the rupture occurs before 24 weeks of gestation, the further away from 24 weeks, the earlier in the gestation from 24 weeks we might well recommend to the patient that termination is or completion of delivery of the pregnancy is the best route since the fetus requires the presence of amniotic fluid for development of the lungs.

So, for example, take a patient who is an infertility patient who has had many years of attempting [150] pregnancy and finally succeeds at pregnancy, reaches 21 weeks of gestation and ruptures membranes. The likelihood of a successful outcome of that pregnancy, even if the patient remains pregnant, is extremely poor to impossible because the fetus may well survive to 30 weeks of gestation and because of the absence of amniotic fluid, when the fetus is delivered as a newborn, it has no lungs to resuscitate. So the mother may go through a prolonged period of hospitalization, increasing positive thought process because she is reaching that point, deliver a fetus which has no lungs and the baby will die in the delivery room.

We will try to encourage that patient to discontinue the pregnancy, but if a patient has been trying for many, many years and this is her last hope in her mind, she will

insist that we maintain a pregnancy. We will then do, we will hospitalize the patient, monitor her carefully for any infection as we would do after the 24 weeks of gestation and look for any opportunity to identify a risk to the mother or the fetus and proceed for delivery, such as the development of an early infection on the part of the mother.
Q Now, in those instances where infection does appear, what would the accepted course of treatment be?
A Once -- once the infection has been identified in developing in the mother, as best we can determine that infection is developing, we proceed to delivery.

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[151] Q Once an infection appears, in your medical opinion, Dr. Bolognese, is there any reason to delay the process, whether it be delivery or cesarean section?
A Absolutely not.
Q What are the risks to the woman if you delay any procedure at the time the infection first manifests itself?
A The initial risk to the mother is an infection within the uterus which causes seeding of infection in the uterus. Then the patient potentially will begin to develop a blood-borne sepsis or spread of the infection throughout her body, which leads to an overwhelming septic infection, shock. And, lastly, if that infection is indeed an overwhelming infection she may develop what's called disseminated intravascular coagulopathy, DIC, which is easier, and that represents her coagulability, her ability to clot off her blood. She loses that ability and she may frankly hemorrhage to death.
[152] Q At the time the infection first appears, is the woman in any immediate danger?
A Not if we move rapidly for a delivery.
Q What are the risks to the fetus of a delay in the

procedure?
A The fetus will also develop an overwhelming infection and if we're dealing with a pregnancy that is either close to viability or beyond viability, the best approach for the fetus is for delivery and treatment with antibiotic therapy, respiratory therapy on the part of the intensive care specialists or neonatologists. So both patients in that circumstance would be at risk and delivery is in both their best interests.
Q When a woman presents an infection can you predict how long it will take for that infection to develop into the other problem, more problematic infections you mentioned a few minutes ago?
A Not -- not -- well, some infections can be chronic, other infections can become life-threatening within a matter of hours.
Q If you delay the procedure and the condition of the woman worsens, will that have any impact on the treatment of that woman?
A Not infrequently if the uterus becomes infected or seeded with infection, the uterus fails to adequately respond to [153] Pitocin and she may not be able to deliver vaginally, we may not be able to successfully induce the labor process or effective labor process and then we're forced to proceed to an operative delivery, which places the patient at more risk. She is then infected, the uterus is infected, the risks of a surgical procedure then are substantial. After evacuating the uterus she may not contract the uterus adequately and begin uterine hemorrhage. We may end up having to remove her uterus or perhaps her entire reproductive organs as a result of a delay in overwhelming pelvic infection, and we still may lose the patient.
Q So to make sure I understand, delaying the process of evacuating the uterus may change the method of treatment you have to employ?

A Absolutely.
Q And the method of treatment you would later have to employ, the surgical method, is considerably riskier to the woman than the vaginal delivery that would occur early at the time the infection is discovered?
A Absolutely.
Q You also mentioned earlier, I believe, and if you didn't, I'll mention it, preeclampsia.
A Yes.
Q Is that a condition that you encounter in your perinatal practice?
[154] A Yes. In fact, preeclampsia and infection and hemorrhage are three of the major causes of maternal deaths in this country. And preeclampsia again is one of the problems we encounter at our institution.
Q What is preeclampsia?
A As best we can determine, it's a combination of symptoms that may well be related to an immunologic problem on the part of the mother. It occurs in the first pregnancy of patients, tends to occur in the younger patient rather than the older patient and, interestingly enough, tends to recur, potentially may recur with a new marriage or a new partner on the part of the patient. The patient develops significant hypertension, she can have destruction of the liver, hemorrhage into the liver, she can have destruction of the kidneys and she may go on to have eclampsia, which is a seizure disorder of the brain, due to the edema that she tends or the excess fluid, water intoxication that she may take on.
Q You mentioned earlier, I believe, the term HELLP Syndrome?
A Yes.
Q What is HELLP Syndrome?
A HELLP Syndrome is a further development of preeclampsia with respiratory distress, an adult respiratory distress syndrome where the patient has a

significant complication in [155] the lungs fluid retention and they go on to die secondary to that.
Q How frequently do you encounter cases of preeclampsia?
A Again, preeclampsia tends to occur more commonly in the lower socioeconomic patient, so that as an urban hospital dealing with urban patients as well as, again, a tertiary care center where complications are transferred in, preeclampsia is a disease that we deal with not infrequently on an ongoing basis.
Q When preeclampsia manifests itself, what is the accepted method of treatment?
A The accepted method of treatment is the diagnosis and then proceeding again to delivery, since there is no cure for preeclampsia, and that a delay may again worsen the maternal condition, as well as causing hypoxia, loss of oxygen, reduction of oxygen to the fetus and possible permanent damage to the fetus.
Q Can you predict at the time that preeclampsia manifests itself what the outcome would be for a patient if the condition went untreated?
A Again it can be a chronic nature or the earlier the onset very frequently can be very severe and a patient can go into a HELLP Syndrome or become eclamptic within a matter of hours.
Q When the symptoms first manifest themselves, is the [156] patient in immediate danger?
A Patient is at risk but not at immediate danger.
Q What are the consequences if you delay the termination of the pregnancy for a preeclamptic patient?
A Again the problem would be the development of eclampsia, the development of HELLP Syndrōme, the patient may go on to seizure, the patient may go on to a respiratory distress and then eventually death. We may also lose the fetus during the course of that time because the mother, as she begins to spasm or contract her blood

vessels, she will reduce dramatically the blood supply to the uterus, hence the blood supply to the placenta and thereby the blood supply to the fetus. So we may end up losing the fetus as well as the mother in a severe case.
Q In your opinion, Dr. Bolognese, once a patient manifests symptoms of preeclampsia, is there any medical reason to delay treatment?
A None.
Q Would a delay in treatment potentially have an impact on the course of treatment?
A Again the decision, the longer one delays, the sicker the patient, the poorer the response or less time one has to induce a vaginal delivery and again you're going to be forced to proceed to an operative delivery and a very sick patient.

* * *

[158] Q Dr. Bolognese, in your testimony you mentioned on a number of occasions delivery of a patient or delivery of the pregnancy. Is that in fact a termination of the pregnancy?
A Absolutely.

* * *

BY MS. MERSHIMER:
[161] Q Have you performed any abortions --
A Yes.
Q -- that you felt were required to be performed immediately, but don't fall within the act's definition of medical emergency?
A Uhm, there would be instances again where ruptured membranes occurred prior to 16 weeks of gestation where again there's no reason to delay the pregnancy -- the termination of the pregnancy or abortion under the

definition of the State of Pennsylvania because there's no chance of viability and a delay would be, again, a potential risk to the mother because of infection. Once the membranes rupture at any stage of pregnancy, the mother is at risk to an infection. So once, whatever time that occurs in the gestation, the decision to proceed to delivery has to be considered, depending upon the circumstances.

Q Any other examples other than ruptured membrane?

A Again there could be instances of significant hypertension where a patient has been poorly controlled, instance of severe diabetes, again poor control on the part of the patient, where delivery of the pregnancy would be [162] justified abortion, depending upon the timing of the delivery, would be justified as a medical emergency.

Q Okay. And for severe hypertension in such cases how soon would you perform the abortion?

A If the patient has poor hypertensive control and becomes pregnant and her hypertension worsens because she has a chronic hypertensive disorder, not preeclampsia as we talked about before, again pregnancy is complicating her hypertension and immediate delivery would improve the circumstance. So in those circumstances that again, you've asked me for instances of emergencies where I would move rapidly, that would be another instance.

Q Okay. And that woman can't wait 24 hours before she had the abortion?

A If she has uncontrollable hypertension which is being worsened by the pregnancy, she can indeed develop a major hypertensive crisis and have a major -- major problems, so again I would move for delivery.

Q Okay. And what would those major problems be in that case?

A She could stroke out.

Q And die?

A Well, that's sort of a major problem, too, but I haven't been thinking quite that far down the road; yes.

Q What happens when she has a stroke?

[163] A Well, she could be permanently paralyzed, depending upon the age of the patient. She might partially recover or, depending on where the stroke was, she might have a hemorrhage and she could indeed die.

Q Okay. Now, in the case of diabetes that you gave, what, the abortion would have to be performed immediately, within 24 hours?

A If the patient has uncontrolled diabetes then she is again in a situation where she is developing ketoaciduria where she could have a seizure or a coma secondary to the diabetic state. There's no reason if the patient requests a termination to move to delay that for 24 hours to meet a regulation, when the best interests of the patient would be served by moving to a delivery or termination.

Q Well, is there some increased risk to her life, her health, by waiting 24 hours?

A If her diabetes is poorly controlled and cannot be controlled well because of the pregnancy then, indeed, I would move for a termination, yes.

Q And what happens, what's the result if there is no termination of the pregnancy?

A The patient may well develop ketoaciduria and may go into a diabetic coma or diabetic seizures.

Q And what does that all mean?

A What does that all mean?

[164] Q I mean, like does she lose her kidney or --

A Patients can again have a major central nervous system disorder as a result of the seizure.

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[165] A Delivery of the fetus at that point or terminating the pregnancy would be recommended to the patient because the likelihood of a successful outcome of a live fetus or live newborn would be essentially zero.
Q So you explain the risks to her of terminating the pregnancy compared to the risk of her carrying that child to term?
A Well, it's not the risk, the risk is to the fetus, largely, of ending up with a fetus that has -- or a newborn with no lungs. We would recommend the termination of the pregnancy because of the outcome of the pregnancy, not risk per se to the mother. We're saying in this instance because the fetus does not have adequate amniotic fluid surrounding it, and that appears to be important in the development of lungs of the fetus, that she, if she carries, continues the pregnancy, that she will end up with a newborn that has no lungs and cannot be resuscitated, so that's what we're talking about.
Q Well, so the woman has absolutely no risk at all by having a ruptured membrane?
A No, no, no. She has risk if she continues the pregnancy, due to infection; that's also discussed with her.
Q Right. Now, you said that if there is a case where [166] there's ruptured membrane and infection has developed, that you would proceed to deliver, is that correct?
A Yes.
Q And you said you would move rapidly for delivery?
A Yes.
Q How rapid?
A Once the diagnosis is made, the patient is moved to the labor and delivery and Pitocin is started.
Q So that would be like in approximately an hour?
A The unit at Pennsylvania Hospital is located right across from labor and delivery so, yes, we can proceed

within a matter of an hour.
Q And if you don't, what happens in the case where a woman has a ruptured membrane and the infection and you don't, fail to deliver the fetus immediately, within an hour or two?
A An hour or two? Nothing may develop or she may start a worsening of the infection process.
Q Well, in the cases that you've handled where there's been a ruptured membrane and there's been an infection, in those cases how quickly did you move to deliver the fetus?
A As quickly as possible.
Q And how fast is as quickly as possible?
A I think I answered that. As quickly as I can move the patient to labor and delivery and begin an induction of the labor process.
[167] Q And if you don't do that, what happens to the woman?
A I think I testified to the fact that if we don't deliver her at all, are you talking about?
Q Mm-hmm.
A The patient can then go on to develop a major infection, she could theoretically lose her uterus, she may go on to an overwhelming sepsis which may lead to shock and possible coagulation problems and death.

* * *

[168] Q In the case of preeclampsia, you said you would proceed to delivery?
A Yes, ma'am.
Q How fast would you do that?
A Again, as soon as the diagnosis is made, we would proceed
to move the patient to labor and delivery, initiate a labor process with Pitocin.

[169] Q And can you tell me again what would happen if you didn't proceed to delivery?
A Patient doesn't, isn't delivered? The pregnancy, per se, is the cause of her preeclampsia, so the patient will then develop extensive hypertension which may lead to seizure, she can bleed into the liver, she can lose her kidneys, she can go on to have a cerebral hemorrhage and possibly die.
Q And HELLP is just a further along development of preeclampsia?
A HELLP is a development of the process where the patient becomes sick enough, she goes on to a respiratory problem where the lungs, in essence her lungs fail her and she requires ventilator support and it's an issue of whether she will -- the lungs will return and she can get off the ventilator or she goes on to die.
Q And does that also occur in fetuses about 18 weeks gestational age earlier?
A Any time the patient has preeclampsia she can go on through a sequence of severity, more severe preeclampsia, go on to eclampsia or go on to a HELLP Syndrome.
Q Is that a way of saying yes, it occurs in 18 weeks or more?
A I'm sorry, yes, ma'am.
Q And again you would deliver the fetus as quickly as possible, once you made that diagnosis of HELLP?
[170] A Absolutely.
Q And, what, she could die if you didn't go ahead and proceed with the immediate delivery?
A If we believe that the cause of the syndrome and the worsening of the process is the pregnancy, then again terminating or delivering the pregnancy hopefully will improve her condition.
Q Jumping back to ruptured membranes, you said that some of the cases that your hospital receives are transfer

cases from other facilities?
A Yes, ma'am.
Q Do you know how long it takes them to transfer the patient?
A Depends on the distance.
Q Well, what's the distance that your hospital usually experiences?
A A more common distance would be within an hour of our institution, although we do have some transfers that go out as far as several hours.

* * *

BY MR. ZEMAITIS:
[171] Q Now, Dr. Bolognese, you drew a distinction at 16 weeks between abortion and delivery, and I believe you said that the source of that is Pennsylvania law, is that correct?
A Yes.
Q Is that the Pennsylvania Vital Statistics Law?
A Yes.
Q If you deliver a fetus that is 16 or 17 or 18 weeks old, does that fetus have any chance of surviving?
A No.
Q Up to what age would it have no chance of survival, what gestational age?
A Approximately 24 weeks of gestation.
Q Now, you said that the preeclamptic patient could go through a series of progressively more severe problems. Does that happen with all patients that experience preeclampsia?
A No.
Q Do some patients with preeclampsia move past the symptoms to a less severe stage?
A Not less severe. They will either -- they will become more chronic or become more acute, but they won't become less sick unless the pregnancy is terminated.

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, et al.	:	**CIVIL ACTION NO. 88-3228**
v.	:	
ROBERT P. CASEY, N. MARK RICHARDS, et al.	:	**Reading, Pennsylvania July 31, 1990 9:35 o'clock a.m.**

. . . . . .

NON-JURY TRIAL - DAY 2

* * *

[4] DR. LENORE E. WALKER, Plaintiff's Witness, Sworn.

THE AUDIO OPERATOR: Would you state and spell your name for the record, please?

THE WITNESS: Dr. Lenore E. Walker, L-e-n-o-r-e W-a-l-k-e-r.

MS. KOLBERT: Your Honor, Dr. Lenore E. Walker has over 20 years of experience as a licensed clinical, forensic and school psychologist.

Currently she is the President of Walker & Associates in Denver, Colorado, and the founder and Executive Director of the Domestic Violence Institute, a nonprofit organization which conducts research and training on family violence.

[5] Dr. Walker is also an Adjunct Professor of Psychology at the University of Denver. During her

career, Dr. Walker has been the Department Chairperson and Associate Professor of Psychology at Colorado Women's College and an Assistant Professor of Psychology at Rutgers University Graduate School of Applied and Professional Psychology as well as Assistant Professor of Psychiatry at the University Medicine and Dentistry School of New Jersey's Rutgers Medical School.

Dr. Walker was one of the first scientists in the nation to conduct clinical research on inner-family violence and is today one of the foremost experts on the psychology of battered women and families.

From 1978 to 1981 Dr. Walker was the principal investigator for the National Institute for Mental Health funded study on the battered women syndrome. She has authored, edited and contributed to over 32 books and articles and professional journals. For her first book, "The Battered Woman" published in 1979, Dr. Walker was awarded the Distinguished Media Award by the Association for Women and Psychology.

In addition, Dr. Walker is a fellow of and has served on the Board of Directors and the Council of Representatives of the American Psychological Association and is Chair of its Women's Caucus.

[6] In 1987 she was awarded one of the organization's highest honors by being chosen as the recipient of its BPA, Distinguished Professional Contributions to Psychology and the Public Interest Award.

Dr. Walker has consulted with and delivered papers to numerous professional organizations, governmental hearings and has testified as an expert witness on domestic violence and the battered women's syndrome in criminal and civil cases in approximately 30 states and in the Federal Courts.

Dr. Walker received her Doctorate from Rutgers the State University Of New Jersey in 1972, her Master's

degree in Clinical School Psychology in 1967 from the City University of New York and her Bachelor's degree from Hunter College of the City University of New York in 1962.

Her curriculum vitae, actually I think it's her resume, is attached as Plaintiff's Exhibit No. 80.

THE COURT: Yes, I have that.

DIRECT EXAMINATION

BY MS. KOLBERT:

Q Dr. Walker, I've told the Court that you're a clinical and forensic psychologist. Can you explain for the Court the kinds of patients that you see and how many patients per year as a general matter you see?

A As a clinical psychologist, which is only part of the work that I do, I see a variety of different kinds of people [7] for both evaluations and for treatment. Basically they are people who come in with all different kinds of problems in living and I use psychological principles that come from abnormal psychology and developmental psychology to try to understand what their problems are and then develop a treatment plan for interventions to try and help them in some way.

I usually see people in psychotherapy usually once a week, but some people need it for a short period of time longer than that. My subspecialization is in violence against women and so I see many rape victims, battered women, but I also work with families, with both men and women and children in this practice.

Q As a clinical and forensic psychologist, as a professor in the field, as an author in the field, do you follow the research and the publications in the subspecialty of family violence?

A Yes, I do.

Q Do you have occasion to review the work of other clinical and forensic psychologists in the field of domestic violence, family violence, sexual abuse and child abuse?

A I do. I serve as an assistant editor on a number of the major journals in the field, both those that are published by the American Psychological Association and those that are published independently. I think it's approximately five of [8] them that I now serve as an assistant editor of, in addition I review for a number of other journals.

Q Would each of those journals, could they be referred to as referee journals?

A Yes. A referee journal is one which will not publish an article unless other peers review that journal, usually it's three people have to review it and decide that it's worthy of publication.

Q Are you a member of the American Psychological Association?

A I'm a member but I have a higher than a member classification, it's a fellow classification.

Q Well, can you explain to the Court what that is?

A Mem-- after you're a member for a certain period of time, if you have made a contribution that is considered substantial to the field of psychology, then your colleagues nominate and elect you to fellow status. And that's a small percentage of psychologists who get that honor and I have been so honored.

MS. KOLBERT: Your Honor, at this time I would like to move that Dr. Lenore Walker be certified as an expert in family violence.

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[9] THE COURT: Your motion is granted.

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[12] Q Have you had an opportunity to examine the Spousal Abuse Statute in Pennsylvania which is 18

Purdon's Section 3128?
A Yes, I have.
Q And is this statute consistent with the definition you would use for marital rape?
A No, it is not.
Q How would you define marital rape differently?
[13] A Well, marital rape, as I understand the statute, and I'm not a lawyer so it's just my own interpretation of the statute, it appears to be more narrow than would be the common definition that I would use and researchers use for marital rape in that it calls for sexual intercourse to have occurred. In my definition I also use other forms of coercive sexual behavior that may not include penetration, but might include serious sexual abuse of sexual organs, other kinds of penetration that might not be with a man's penis in the woman's body. And so it would be a little bit broader than what that definition would call for, but it would also be coercion.
Q Now, are you familiar that in the Spousal Sexual Assault Statute there is a reporting requirement of 90 days?
A Yes, I am.
Q Is the limitation -- I refer you to Subsection C of that section -- is the limitation of reporting to law enforcement personnel within 90 days within your definition of marital rape?
A No, it is not. That is an overly narrow time period. One of the psychological effects of having been raped is that women often in order to dull the pain of the memory of the rape try to deny or forget the actual rape itself and it can sometimes take several years before she is able to talk about a it or to report what has happened to her.
[14] Q Are there any particular type of women who are battered?
A No.

Q Can you give the Court a description of the range of women who fall within that category?
A Yes. All of the research, mine as well as that of other researchers, indicates that battering occurs across every single demographic group that we know, rich women are battered and poor women are battered. Women -- so it goes across all class levels, women who work and have careers and are well educated are battered as well as those who have no education and have no job skills. All different racial groups are battered, all ethnic groups are battered, all religious groups are battered. There is no way to predict who might become a battered woman.
Q How about the age range of women who are battered?
A Well, in my own research the age range ran from the age of an adult, which was 18 years old, even though we know that teenagers are also abused, all the ways up through women in their 70's and 80's.
Q Are there any particular type of men who are likely to become abusers?
A. Again there are o particular demographic group, just as for the women. Batterers come from every single one of the sociological demographic group. There is one factor, however, that is more likely to predict whether or not a man [15] will become a batterer and that is witnessing and experiencing battering in his own childhood home. A man, a boy who watches his father, who observes his father battering his mother, is 700 times more likely to use battering in his own home. And if he also has been abused himself, that raises the risk to 1,000 times more than a man who has not witnessed or experienced such abuse.
Q Could you describe for the Court the kinds of abuse that a batterer would use?
A Well, abuse ranges across physical, sexual and very

serious psychological levels. Physical abuse can take minor forms such as pushing and shoving and slapping, all the way--

MS. MERSHIMER: Your Honor, I'd like to object at this point. I don't see the relevance of the various types of abuse. The statute that we're challenging here requires spousal notice and then it also has an exception for if a woman fears, "If a woman has reason to believe that the furnishing of notice to her spouse is likely to result in infliction of bodily injury upon her by her spouse or by another individual."

Dr. Walker has been proffered in her expert report to testify that battered women are not likely to avail themselves of the exception. I don't see why getting into the details of how battered women are indeed battered which the Commonwealth does not dispute that there are battered [16] women in this world, is relevant to this whole line of questioning.

THE COURT: Ms. Kolbert, is this relevant or are we going off on tangents here?

MS. KOLBERT: Your Honor, I think it's very relevant. We are prepared to prove through Ms. Walker's testimony and testimony of other witnesses that not only are battered women -- will not avail themselves of the exception, but they're psychologically incapable of availing themselves of the exception and therefore will suffer the harms that this statute requires them to notify their husbands. The types of abuse that we're talking about are the very harms that will be inflicted upon women in the state as a result of the statutory language.

THE COURT: Overruled; I believe this is relevant. Also, I think it's desirable to produce a complete record and I'm just reluctant where a party does have a theory of relevance to shortcut that and perhaps have a record which is not as complete as it should be.

MS. MERSHIMER: Your Honor, so that I'm not

popping up all the time, can I have a continuing objection to this line of questioning?

THE COURT: Yes, you may.

MS. MERSHIMER: Thank you.

THE COURT: Shall we continue?

[17] BY MS. KOLBERT:

Q Dr. Walker, I think you were trying to describe the kinds of abuse that a batterer might use.

A Yes, I started with some of the more mild forms of physical battering and it ranges all the ways up through throwing a woman across the room, banging her head against the floor if she is knocked down, kicking her both with shoes on and with shoes off, pulling her hair, dragging her from place to place, to the use of objects and weapons with the battering, including throwing all kinds of objects that are found in the home, tying her up with objects from the home, using guns, knives, hatchets, hammers, whatever is available to cause extreme damage to women, burning them, poisoning them. Every time I think that I have heard the worst, I am asked to review and evaluate another case where there are more forms of torture that I could never have thought about.

Q Now, does battering take other than physical forms?

A Yes. In addition to physical abuse there is also sexual abuse within a battering relationship. When I first began my research I kept the physical and sexual abuse together as one category, but as I began to collect my data, I realized that sexual abuse is so difficult for women to speak about that it needed to be looked at in a separate way. And the sexual abuse ranges from being forced into unwanted intercourse through the use of being tied up, having objects inserted [18] inside of their body against their will, being mutilated sexually, having parts of their organs cut and being physically abused while being sexually abused, as well.

Q Now, Dr. Walker, would that also include sexual

abuse as defined by the Spousal Sexual Abuse Act in Pennsylvania?

A Yes, it would include that, then there's also the psychological abuse. And that has been the most difficult to measure because it's been very important, both as a researcher and as a clinician, to separate the normal kind of psychological dysfunction and the cruelty that happens in a relationship when that relationship starts to unravel and deteriorate from actual psychological abuse. And my research spent a lot of time trying to figure out what are the differences when it goes beyond the normal kind of verbal and psychological abuse that happens or psychological coercion that might happen in a dysfunctional relationship and in an abusive relationship.

And I have now settled on the definition that's used by Amnesty International for psychological torture as the best description of the psychological abuse that happens in a battering relationship. And they include a number of different factors that include verbal degradation, cursing and name calling and terrible putdowns. It includes denial of a person's powers. For example, for a woman that might mean telling her she's -- she can't do things in the house, [19] she doesn't take care of the children well enough, she doesn't cook well enough, even though she may indeed be adequate at doing those kinds of jobs. It includes attempting to have some kind of physical deterioration of the woman's body so that she's unable to function, such as being woken in the middle of the night and forced to sit up late for hours at night, listening to what the man has to say, and not being permitted to sleep. It may include food deprivation and other physical forms of debilitation and it includes isolation and monitoring of the woman's activities. So that men who batter women stalk them, find them, always have to know where they are and what they're

doing and they want to know what they're thinking, as well. The women describe it as the need for power and control, and particularly mind control over their activities all of the time. They become over-possessive and may become pathologically jealous. Much of that jealousy centers around sexual jealousy, and so they're often accusing the woman of having affairs with other people when most battered women have enough trouble with the one man and they're not going to be out having affairs with other men, although some women of course do that. It's a very small number compared to the, I think in my research, almost over 90 percent of the women said that they were being accused of sexual jealousy.

Q Dr. Walker, can abuse also take the form of harm to [20] children or to other persons in the family?

A Yes, it can and does take that form. For example, in my own research, 55 percent of the women said that the men who battered them also physically battered their children, which is a high number. There is a new study that has just come out of Denver, Colorado, that shows the overlap between child sexual abuse and battering of women at about one-third of all of the cases that the Department of Social Services in Denver has seen. And those kinds of figures are being replicated across the country.

Q Can abuse also occur in the economic arena, using economic coercion rather than physical or psychological coercion?

A Yes. Many men actually starve women and children. They do not give them a sufficient amount of money to feed, to clothe, to shelter their families. In many of those cases the women may actually work outside of the home for money and they are forced to turn their whole paycheck over to the men. In a recent case that I have been working on, all of the children were also forced to

turn their paychecks over to the man and he gave them two dollars a day spending money and he kept all of the money and had the power and control over how it was used. Now, that kind of economic deprivation is common in both homes where there is a lot of money and as well as in homes where the man may not even work or bring [21] home money.

Q Now, you've testified about a range of violence. Do we know anything or do you know anything as a researcher about the scope of this violence, both within the United States and here in Pennsylvania?

A Well, it's been very difficult to get incidence and prevalence figures, exactly how much violence there is, because battered women are very reluctant to talk about it. When I first began my research back in the middle 1970's, very few people had even heard of battered women. Of course, that is no longer true today. We have, in offering women some safety and some protection, some of them have come forward but it's still a very small number and generally they don't come forward until the violence is at life-threatening proportions. So that even though there are many women who are being battered today, we still don't know about who they are.

The best estimates, my estimate is that one out of two women at some time will become battered in their lives. The researcher who has collected the best empirical data is a sociologist named Murray Straus and his colleagues at the University of New Hampshire's Family Violence Research Center, and his research shows that between 25 percent and 33 percent of all women in the United States have been physically abused at least one time in the year that they [22] collected their information, and so that's just for a one-year period of time. So the estimates are very, a very high percentage of women will be battered.

Q Do you have any reason to believe that the statistics in Pennsylvania or the prevalence rate in Pennsylvania is any different than the national figures that you've cited?

A No, there is no reason to believe that they're any different. In fact, I have been in the State of Pennsylvania as a trainer for those programs that provide services to battered women since the late 1970's. The most recent time was just this past September of 1989 where I was a keynote speaker for the Pennsylvania Coalition Against Domestic Violence and the Alcoholism Treatment Providers, where they had a joint conference here. And there's every indication that in the State of Pennsylvania the statistics are the
same.

Q Do you as a scientist have any estimate of the prevalence rates of homicides that result as a result of wife battering?

A Yes, the best estimates are for husband and wife homicides, about 25 percent of all the murders in this country occur in homes where there's violence.

Q How about a prevalence rate for spousal sexual abuse which in defined by the Pennsylvania statute?

A I have no idea of what the prevalence rate would be. The figures that we can get from official statistics are very [23] small because most women who are sexually abused in a marital situation simply do not report it.

Q What is your estimate of the level of marital rape at this point?

A Well, in my research we attempted to measure sexual abuse within the marriage and when you ask the question "Have you ever been forced into having sex against your will," then we found 59 percent of our sample of 400 said that they had been. When we asked how many of them had reported it, I am not even sure one said yes.

Q And do you have any estimate of the prevalence of

violence against children within a battering family?
A Again, we -- we believe that over 50 percent of the battering relationships, children are also physically abused. We think about one-third may be sexually abused and psychological abuse is probably all of the children who watch a father or hear, lay awake at night hearing a father batter a mother would be considered psychologically abuse.
Q Now, Dr. Walker, you've talked about a range of very horrendous abuse and I think most people want to know, and I would like to know today, why do women stay in abusive relationships, why don't they just leave, call the police, call a battered women's center and just leave the relationship?
A Well, the question of why women don't leave has been the [24] question that has caused most people the most difficulty in understanding battering relationships and it's a complicated answer to why women don't leave. And it ranges, the complications range from fear of being killed or more seriously hurt when they do leave all the ways to the psychological theories of not being able, rendered helpless and rendered with lower self-esteem so they are unable to leave psychologically.
Q Now, you testified earlier that you studied the theory of learned helplessness in your study. Can you explain that to the Court?
A Yes. If you can bear with me for a few moments, it's a complicated theory, but I found it to be one of the most helpful ways of understanding what happens in a battering relationship.

In the mid 1950's and late 1950's when I went to school, I read of some research that was being done by a psychologist named Martin Seligman who --

THE AUDIO OPERATOR: Would you spell that, please?

THE WITNESS: S-e-l-i-g-m-a-n. He studied and

was trying to find a new way of understanding depression and he wanted to create depression that comes from external sources. At that time we believed there were two different ways that you could become depressed: one was from internal biochemical changes in your body, the other was from stresses or external [25] kinds of events. He wanted to see if you could create depression in the laboratory and so he used animals and then he went on to studying people. And I took his work one step further to looking at battered women.

When he first started with his animal research, he started with dogs, and he put them in, at that time it was called a shuttlebox. One side had an electrical grid and the other side did not, and there was a barrier between the cage between the two sides, so the dogs sometimes could escape and leave and sometimes it could not do so.

Today we could never do these kinds of experiments, but in those days that was routine kind of work for animal psychologists.

What he found was that if he gave the animals random and variable electrical shocks so the animals could never predict when they were going to be hurt or when they would be safe, and if sometimes he let them escape by taking out the barrier and sometimes he did not, that at first the animals would try to escape and then they just found a part of the cage and they lied in the cage. Sometimes they would defecate and lie in their own fecal matter in the cage and not even attempt to escape when he would open up the barrier.

Now, the earliest reports suggested that these dogs had been -- that they had produced learned helplessness, and hence they gave it that name. In fact, as he began his later [26] experiments, that name is really an erroneous one because they don't learn to be helpless, they learn to lose the ability to predict that what they do will make a difference to what happens to them.

Now, these dogs, although they appeared to be very passive, in fact found the part of the cage where the electrical current was the weakest. Electricity just does not go across all of those coils on an even level, and fecal matter is a good insulator from electrical shock.

And so what appeared to be being helpless actually was a coping strategy for these animals to minimize the amount of pain that they received, once they believed that it was inescapable pain. And they stopped trying to escape, instead developing coping skills.

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[27] In order to measure the thinking or cognitive processes or the affect or feelings, Seligman went on to work with college students.

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[28] And it was, of course, time limited from just the one experiment, but he demonstrated that indeed you can change a normal, healthy person's way of functioning if you subject them to what they perceive as inescapable random and [29] variable aversive or painful stimulation.

Now, I thought about that and thought about the battered women that I was dealing with, who even though I would sit with them and help them try and find ways to leave the battering relationship, much like Seligman's dogs, they just were unable to follow through with any of their measures that I would help them devise. And I wondered if, indeed, in the natural environment -- now not in the laboratory that Seligman made -- but in the natural environment of a battering relationship could there be the random and variableness of the pain from a battering relationship that would teach a battered woman that she did not or could not

predict that her actual responses would actually make a difference in what happened to her and her safety, and would that then cause her to not use her natural judgment and would it make her appear -- at that point we were looking at both depression and anxiety, without recognizing that there was a battered woman syndrome that would incorporate all of that. And so the work that I did and part of the research that I did was to measure whether or not that would happen and, indeed, I found that there were five factors in childhood experiences that would indicate a higher risk of developing learned helplessness and seven from a battering relationship. I used some of the same tests that Seligman used before and after with his college students, I used with the battered [30] women so that I was able to make those kinds of comparisons.

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Q Did your research discover anything about the cycle of violence that occurs?

A Yes. That was the second area that also needed to be measured. In psychology when we talk about why the people's behavior is maintained, we look at learning theory as one of the theories to help explain that to us. And in my work, what I found was that battering did not occur all of the time [31] in a battering relationship, but neither did it occur in the random way that most battered women and batterers perceived that it happened, that there really was a cycle that occurred and that that cycle had three phases to it. And my research attempted to isolate the cycle, measure it, and today we use it as one of the primary methods of teaching battering -- couples who are involved in battering to recognize their own cycle so that we can attempt to try and break the learned helplessness that may result from

the three, the experience of those three phases.
Q Can you quickly describe for the Court what those three phases are?
A I can. I could also chart it, which might speed it up a bit.

MS. KOLBERT: If that's all right with your Honor?

THE COURT: Yes. You want to step down? Keep your voice up, we are recording this. Perhaps a microphone can be moved over near the chart. Counsel may move around if they wish to see what is being done.

THE WITNESS: If you look at a graph with this line being time and -- the horizontal line -- and the vertical axis is being levels of tension and dangerousness and this being zero, zero level of tension and dangerousness and no time, the three phases include the first phase, which I call the [32] tension building period. Here are little battering incidents that occur and the tension goes up a little bit, the dangerousness a little bit and let's say an early, a low level violence incident, and then it comes down some, but it doesn't go back to zero in that first phrase, it stays around here and then goes up a little bit more, comes down, goes up a bit more with another incident, comes down, and maybe it stays for a while and then might go up again. I usually use a zero to ten scale just to help explain the relativity of the violence, with about eight being the level of danger where there's a life-threatening incident that could occur.

And if you end about here, let's say, in the tension-building phase, there comes a period of inevitability where if the couple is not separated at this point, it's going to go to phase two, which is the acute battering incident or the explosion, and that will just -- perhaps, such as this.

The tension then comes down. Now, physiologically it is reinforcing for there to be a lack of the tension which has been discomforting up until this point, and so

that in and of itself, the ending of the incident, is a reinforcement for the incident to get over with.

When we have police involvement, we often have it after an acute battering incident. Rarely will the police ever be involved at this level, even though these are [33] battering incidents and there may well be some physical damage that occurs at this time as well. So it's usually over here where women might notify somebody that something has happened and in most research studies, less than 50 percent of the women do do the notification.

At this point we enter the third phase, and this is the most important phase in terms of why battered women will often stay in the relationship. This is the period that I called loving contrition. Here is where the man often says he's sorry. Sometimes he doesn't use the words, but he does something nicer for her. He may give her presents, he may do something that she would like him to do that he might not have done otherwise. In many ways he shows her that he's sorry and he promises that it will never happen again. And most batterers that I have worked with and people -- other people have worked with really want to believe that they will not do it again, that they understand that they have hurt her and have gone too far. And during this time he shows his other side of his personality, his charming side, and his loving side.

Now, this phase works also because prior to the battering or the tension building starting, there is a period of time, often during the courtship of battering relationships, where the man is very loving, very nurturing, spends a lot of time with the woman and really makes her feel [34] like he loves her more than anyone or anything else in the world. It's even more than in most normal relationships during this period of courtship time, and this helps the woman remember what he was like when the mean, cruel part of him didn't

exist. And so this is the reinforcer for staying in the relationship and the two theories together, the theory of learned helplessness and the cycle of violence that occurs are important in trying to identify why women stay, how the battering relationships hold together and then, of course, in developing intervention plans to help break the cycle of violence within these relationships.

BY MS. KOLBERT:

Q Thank you, Dr. Walker. Let me ask this: have you studied or do you have any findings about the communication patterns in partners in both dysfunctional relationships and abusive dysfunctional relationships?

A Yes, we do. The communication patterns in battering relationships are very different than communication in both relationships where there is marital dysfunction and in normal relationships.

In normal relationships we find that there are far more positive than negative interactions when people communicate with one another. In relationships where there is marital dysfunction, we find the opposite, that there is more negative than positive communication patterns.

[35] Q Let me stop you there. When you say marital dysfunction, are you talking about the abusive families that we have just laid out for the Court or another kind of family?

A No, I'm talking about families which are in distress of some kind, but not abuse, where there is not abuse as I would define it and as I defined it earlier for the Court would take place. So in those relationships we know that there are more negative communication patterns than positive communication, but they're evenly distributed across the time of the relationship.

In abusive relationships there is also more negative than positive communication, but they don't occur evenly distributed, they occur in -- in blasts, if you will, or in

chunks of time. A research named Gerald Patterson calls it chaining and fogging. One even chains off and follows the next event and it creates an inability to communicate effectively in those relationships.

Q In the field of psychology is there a diagnostic system that psychologists use?

A Yes, there is.

Q And what is that?

A The current diagnostic -- there are a number of diagnostic systems that are used, but the current one that is most popular in this country in called "The Diagnostic and Statistical Manual of Mental Disorders" and we are now using [36] the third edition which has been revised. And it's abbreviated the DSM-3R.

Q Is there a category in the DSM-3R for women who are battered or come from abusive dysfunctional families?

A No, there is not.

Q Is there a category that you use in diagnosing battered women?

A Yes, there is.

Q And what is that?

A The category that is used is called the post-traumatic stress disorder category and battered women syndrome, which is the collection of psychological symptoms that occurs after exposure to battering is considered a subclassification of that post-traumatic stress disorder which is abbreviated as PTSD.

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[38] Q Can you describe for the Court the criteria for establishing post-traumatic stress disorder?

A Yes. There are five specific criteria that must be met before a post-traumatic stress disorder is diagnosed. Two of them are called threshold criteria and three of

them are psychological symptomatology.

The two threshold criteria, the first one is Criteria A on the chart, and that says that the trauma that is experienced must meet certain kinds of stipulations that are listed in the descriptions, that it has to be an event that is outside the range of usual human experience and that [39] it would be markedly distressing to almost anyone, which basically means that you can take any normal, healthy person, expose them to such a trauma and that that trauma will cause, be expected to cause psychological symptoms in that person.

Now, there is a psycho-social stressor rating scale, hard to say, in the DSM-3R, that helps the clinician make the diagnosis of that particular criteria, and that rating scale ranges from a zero to a six.

Most people who work in the fields of post-traumatic stress disorder believe that anything in the Level 5 and Level 6 meet that threshold. Sometimes a trauma under that could cause a PTSD or a post-traumatic stress disorder, but it wouldn't automatically be considered relevant or part of that criteria.

Q What are the symptoms of post-traumatic stress disorder once the diagnosis -- once the threshold stressors have been identified?

A Then there are three major symptom categories that you have to meet and they are very specifically listed. The three of them include changes in the way people think in their cognitive abilities, that are, in those changes and those distortions, are enhanced by memory problems.

The second group of symptoms are avoidance symptoms or a depression kinds of symptoms and the third group are anxiety symptoms or what we would call higher arousal of the [40] organism kind of symptoms.

And if I may just give a quick example, in the first group of memory kinds of distortions and distortions in

the way people think, one of the major difficulties in working with somebody who has a post-traumatic stress disorder is every time they have to talk about it, they not only remember what they're specifically talking about, but they also remember all of the other battering incidents that have occurred and they start to have not just the memories of it in their head, but they begin to re-feel all of the feelings that occurred at that time, so that they are reinfecting themselves every time that they have to talk or think about the kind of trauma, the battered women the kind of battering that has occurred.

In the other symptoms, the pressure symptoms and the anxiety symptoms, are unusual in that they occur together, rather than separately as would be more commonly found in those disorders.

Q Now, Dr. Walker, you've talked this morning about why women don't leave battering relationships. Is everything that you've said about why they don't leave also true for why they do not tell other people about the battering?

A Yes, it is.

Q And that would be true for women who are battered as well as victims of marital rape?

[41] A That's correct. There is also much denial and minimization because of the need to avoid the pain that every time they would talk about it and think about it would occur again.

Q Are there any periods of time within a relationship when the frequency of battering increases?

A Yes, there are.

Q And what are those times?

A The most natural time for an increase in severity and frequency are during pregnancy when there is one infant in the home and when there are teenagers in the home. Those three periods have been found to have the greatest increase. When I do my work in plotting out

the cycle of violence you can see the differences in the patterns that occur over a long-term relationship at those times.

Q Are you saying then that just the notice of a pregnancy can well be a flash point for violence within a relationship?

A It certainly can be. First pregnancies in fact tend to be one of the most common times that men escalate their violence, sometimes from psychological abuse to physical abuse.

Q Are there any special populations of women that are particularly unable to escape from abuse?

A Well, there are certain populations such as women who live in small towns, rural areas, and certain small groups of [42] people such as in Appalachian country or on an Indian reservation that will have a greater difficulty in seeking resources because everybody, there is no confidentiality, everybody knows what's happening to them, and that does cause more difficulties in being able to leave and escape from a battering relationship.

Q Dr. Walker, the notebook in front of you with the manila tabs, at the very back has a tab entitled the Abortion Control Act. Are you familiar with the Abortion Control Act?

A Yes.

Q Now, I'd ask you to turn to Page 7 of that document and look at Section 3205 which is the informed consent provision of the act. Do you have an opinion about how the 24-hour waiting period required by Section 3205, from the time that a woman obtains -- I'm sorry, from the time that the woman obtains information and gives her informed consent until the abortion is performed will affect battered women?

A Yes.

Q And what is that opinion?

A In my professional opinion it will be a detrimental

effect on battered women. One of the criteria for post-traumatic stress disorder is even understanding information that's given to a battered woman is going to be filtered through their knowledge and fear of increasing their likelihood or risk of being battered again. And so there is [43] a heightened hypervigilance to any kind of cues of danger and for women during that period of time, they can be predicted to be far more anxious and have many more flashbacks to battering incidents during that 24-hour waiting period which will, like the experiments that I talked about for those people who developed the learned helplessness, will cause distortions in their judgment and in their affect, their feelings and in their behavior during that period of time.

Q Now, earlier you testified about how women in abusive relationships are closely monitored. Do you have an opinion about whether or not the 24-hour waiting period will affect battering relationships as a result of that monitoring?

A Yes, I do.

Q And what is that opinion?

A In my opinion, battered women and batterers are so closely attuned to one another that she will be frightened that he will know what is happening and know that there is this special period of time and be more scared, more frightened, and that he will use that as an excuse to batter her. And so the likelihood of her being able to keep this information from the batterer is greatly reduced. Most batterers are so sensitive to what the women are behaving and thinking and feeling that he will pick up something is different and harass and badger her and batter her.

Q Now, Dr. Walker, I'd like you to turn to Page 20 of the [44] act. Are you familiar with Section 3209 which requires that a woman, prior to having an abortion, notify her husband?

A Yes, I am.
Q Let's hold up for a second in discussing the exceptions to that notification, but do you have an opinion about notification as to how it will affect battered women?
A Well, battered women, if they increase -- the period of pregnancy is a time when abuse is increased, the risk of abuse is increased, notifying, just simple notification will have a much higher predictability that a woman will be physically, sexually and/or seriously psychologically abused.
Q Now, some people have proffered a theory that women ought to be forced to notify their husbands because, especially in abusive relationships, the husbands are going to find out about the abuse at some point in the future and the abuse will be worse if the husband finds out that the woman was trying to hide it from him. Do you have an opinion about that theory?
A Yes.
Q And what is that opinion?
A Well, I think that notifying, forcing a battered woman to notify her husband is like giving him a hammer to just beat her with. The probability of her being battered is much greater if she is forced to notify him. In battering relationships you can force her to talk to him and you cannot [45] force communication and if you do, you will be fostering negative and abusive communication in those particular kinds of relationships.
Q In my hypothetical there was an assumption that the husband will find out anyway. Do you have an opinion about whether or not that is true in most battering relationships?
A It certainly is possible that he will find out, but it is also possible that he will not find out if she is given the ability to go forward with what she chooses to do without being put under any kind of onerous procedures or

regulations.
Q Dr. Walker, if a woman believes that her husband will harm her if she tells him of her pregnancy, is her perception of her harm likely to be accurate?
A I'm sorry, would you repeat that?
Q If the woman believes that she's going to be harmed, if she tells her provider that she thinks that her husband is likely to harm her, is that perception likely to be an accurate one?
A Usually it is.
Q Will notification, forced notification guarantee discussions between spouses?
A No. Forced notification will not that there can be any kind of discussions. In battering relationships where the man must have power and control, there are rarely discussions [46] when she raises an issue. It's usually when he raises an issue and wants a discussion that it might take place.
Q Will forced notification improve the communication in any way between the batterer and the woman?
A No, it will not.
Q Now, Dr. Walker, within Section 3209, beginning on Page 21 of the act, there are exceptions, beginning in Subsection B. I would like to ask you to refer your attention to Subsection B(2), which indicates that there is an exception where her spouse, after diligent effort, could not be located. Do you have an opinion about whether or not that exception can be utilized by battered women?
A No -- yes, I do have an opinion.
Q What is that opinion?
A Well, when I read it, I smiled to myself because most batterers stalk the woman, whether or not they are living together, and so it's rare that you would not be able to find a batterer. Most battered women would be delighted if that were the case after they've terminated

the relationship, they would not want to find him.
Q I refer your attention to Subsection B(3) -- let me go back a second, I'm sorry. Strike that question and let me ask a followup to the diligent effort question. Would a woman who made diligent -- who has left her abusive spouse, who is making a diligent effort to find him place herself in [47] jeopardy in any way?
A Yes, she really does place herself in much greater jeopardy of being killed. The risk of a battered woman being killed in this country today has increased and the time when she is most likely to be murdered by her husband is at the point of separation and termination of the relationship. The latest data suggests up to two years she is in greater danger of being killed by this man.
Q I refer your attention to Subsection B(3) which provides an exception where the pregnancy is a result of spousal sexual assault as described in the Pennsylvania statute which has been reported to a law enforcement agency having the requisite jurisdiction. Do you have an opinion about whether or not this section will be utilized by women in abusive dysfunctional relationships?
A Yes, I do.
Q And what is that opinion?
A In my opinion this section will rarely, if ever, be used by battered women because they will rarely report to a law enforcement agency that they have been sexually abused.
Q In your experience have many women within your own client base reported spousal sexual abuse to law enforcement personnel?
A In my experience they do not report sexual abuse to law enforcement personnel. Even if they want to, many of the law [48] enforcement personnel they are not willing, able to hear what the women are saying. Women have a great deal of difficulty talking about sexual abuse and so the information simply is the most

difficult to get.
Q Now, I direct your attention to Subsection B(4) which permits an exception to the husband notification where the woman has reason to believe that the furnishing of notice to her spouse is likely to result in the infliction of bodily injury upon her by her spouse or by another individual. Do you have an opinion about whether or not women within abusive dysfunctional relationships are likely to avail themselves of this exception?
A Yes, I do.
Q And what is that opinion?
A My opinion is that they're not likely to avail themselves of this exception.
Q And why not?
A Well, there are several reasons. The first reason is that battered women do not trust professionals and they do not trust that the information will be kept confidential, and so that will limit their ability to report or to use that particular section. In addition, another reason is that many battered women believe that they will be psychologically abused. And for most battered women, when you ask them what is the most serious thing that happens to them, the worst [49] thing that happens to them, it's the psychological coercion and the harassment and degradation that occurs. And so if the requirement that it has to be infliction of bodily injury at that particular time would be something that a battered woman would not likely or not necessarily believe what would happen, although she would indeed believe that she would be abused by the man should she have to notify him.
Q Now, Dr. Walker, we've spent some time this morning discussing the theories of learned helplessness and the cycles of violence, as well as the diagnosis of post-traumatic stress disorder. In your opinion, are these

three psychological phenomenon responsible for the inability of women to report that they have been abused and sign an affidavit that they are likely to -- let me get the exact language of the statute -- that they are -- "Likely to result in the infliction of bodily injury upon her by her spouse or another individual"?

A Yes, they certainly are very much responsible.

Q So you're not just saying it by -- let me ask you this: Are you saying that she is not likely to do it or that she cannot do it?

A I'm saying that most battered women cannot do it. They don't self-identify very easily and they don't have the psychological ability to be able to avail themselves of that exception.

[50] Q Do you have an opinion about whether all battered women would be covered within the exception as stated in Subsection B(4)?

A Yes.

Q And what is that opinion?

A Not all battered women would be covered by this exception. Those who experienced serious psychological abuse such as the psychological torture described under the Amnesty International definition would not be covered. Those women who are sexually abused in a way that is not covered by the sexual assault statute would not be covered. Those women who are unable to report the sexual abuse that they experience would not be covered and those battered women who do not define themselves as battered women or who are not prepared to terminate the battering relationship, psychologically prepared to terminate it, would not be covered.

Q In your opinion will forced communication as required by Section 3209 of the act, husband notification of her abortion, improve marital integrity in any way?

A Absolutely not. It will not only not improve it, but it will increase the probability and likelihood that a woman

will be seriously battered.

Q In your opinion will the forced notification provision of Section 3209 of the act improve family communication in any way?

[51] A No, it will not improve family communication in any way. If anything, it will make family communication much more difficult and much more dangerous in these relationships.

Q Dr. Walker, have you ever heard of the term "post-abortion stress syndrome"?

A Yes, I have.

Q Is this a recognized syndrome in the field of psychology?

A No, it is not. It has been raised by some psychologists as a possibility, as a trauma. It does not raise, an unwanted pregnancy does not raise to the Level 5 or 6 in the threshold level for a PTSD diagnosis. In addition, when I was on the Board of Directors at the American Psychological Association, because the press had reported that there was such a syndrome, the Psychology Association decided to review all of the scientific literature to see if there were any reports that were based on rigorous scientific studies and there were absolutely no studies that supported the existence of such a syndrome.

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CROSS-EXAMINATION

BY MS. MERSHIMER:

[52] Q Dr. Walker, that study of 400 battered women, how did you obtain that pool of women?

A We advertised in many different ways. We used some battered women shelters, we used mental health centers, we went into businesses and put signs up in the ladies rooms in businesses to get some of our subjects,

we attempted to find as many self-referred, self-identified battered women.

In addition, as the -- we monitored, we did what's called the stratified random sample, it's certainly not random because we didn't knock on everybody's door. We wanted to make certain we had enough people across different demographic groups, so we monitored as it came in. And when we saw we were not getting a sufficient number in a particular group, we then went out and looked specifically for that group.

The only two groups that we had such difficulties with were native American population nd the older women, nd so we had to make a concerted effort to find some other of those people in those categories. No, excuse me, the other group was rural women as well, and so we hired interviewers to actually go out to rural areas because they -- we found that they couldn't come into the metropolitan Denver area.

Q Well, when you say you made a concerted effort to get these women, but you didn't knock door to door?

A That's correct.

[53] Q Well, would you just go and focus again on the shelters or agencies that treat or help battered women?

A No, in 1978 there were just very few agencies that would treat battered women. Today it would probably be easier to get such a sample pool. And so what we did do was we went into communities where there would be older people in some of the housing specifically for senior citizens and actually conducted some of the interviews there so that people didn't have to come out. We hired interviewers and trained them. We -- our sample pool was drawn from a six-state, at that time it was HEW region, today it would be Health and Human Services region. And so we hired people to actually go to rural areas and interview in the areas and, again, we put notices up, we had newspaper and public service

announcements on television and on radio, so that we got the broadest possible coverage in order to get the word out that we were looking for subjects.

Q And then these women would come forward and voluntarily give you interviews?

A That's correct.

Q And do you know how many of the women in your group of 400 were married?

A I don't. I have some of the statistics here that are published in the Battered Woman Syndrome book and I don't believe that we took those details of whether they were [54] married or not married, although we may have some of it somewhere, I just haven't been able to find that number.

Q So you don't have an estimate even?

A I don't. Most of them were, but certainly some were not.

Q Well, I'm just kind of curious. How do you know that most of them were if you don't have the statistics?

A Well, I mean, the study, the analysis is now almost ten years, well, 1981 we completed the analysis, so it's about nine years. At that time we were trying to find out what the average length of time was for a battering relationship and the one statistic that I do have is our comparison with the NORC data, the -- and I forget what those initials stand for, but they were sociological data that came from the census that compared the length of time of the average marriage and the length of time of the average battering relationship that we studied. And our statisticians told us that the percentage of married women were high enough to be able to use those kinds of comparisons.

Q Is sexual abuse a form of physical abuse?

A Well, as I testified to, it certainly could be but there are certain distinctions to sexual abuse that make it no longer considered. And you have to consider it

separately from physical abuse because it is different.
Q Well, I understand you have the two categories, but sexual abuse is a type or a variation of physical abuse, is [55] that correct?
A Again, most women would not define it that way and so we just don't use it as a form of physical abuse. There are times when, particularly in a marriage, when a man will sexually abuse a woman without physically hurting her because she submits to the sexual abuse. And so because of those differences, we don't consider it automatically a category of physical abuse.
Q In the vast majority of cases, sexual abuse involves some sort of physical contact, is that correct?
A Yes, I would imagine so.
Q When you said that one out of two women will be battered at some time in their life, where did you get those numbers from?
A Those are the estimates that I have produced and that comes from a combination of my clinical work and my research work. It is an estimate and it is one now that is standard in the field, most researchers and practitioners, clinicians use that as the estimate.
Q And is this published somewhere?
A Well, it's certainly published in my writings and it's published in a number of other people's writings that I have seen.
Q I want to understand. Were you testifying this morning that battered women, that they don't have the ability to use [56] their natural judgment very well?
A On some things that is true.
Q Is a battered woman likely to make major decisions without telling her husband?
A Yes.
Q When you were testifying about the 24-hour waiting provision and you testified, am I correct, that the women as they're receiving the informed consent or options

counseling, whatever, in an abortion clinic, they're understanding that information through a filter of fear?
A That's correct.
Q Are you saying that battered women then should be given no time to consider informed consent information?
A No.

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[57] Q You've testified that the men tend to be very possessive and know the whereabouts of the women that they batter, is that correct?
A Yes.
Q Are battered women then going to be less likely to be able to get out of the house to get counseling for abortion services?
A That's correct, it will be more difficult.
[58] Q Is it going to be more difficult then for a battered woman to even obtain an abortion in the first place?
A That is correct.
Q Would you agree that battered women are in more need of counseling than your average woman that seeks abortion?
A No, not necessarily so.
Q Even though they are having information, they're filtering that information through this filter of fear, as you said, they don't need extra counseling?
A Not necessarily. They need the ability to be -- have their own needs respected, so they need a counselor, as most counselors that I've worked with who are trained to do, to be able to listen to them and talk with them, but not have any enforced periods of time or regulations on the amount of time that it may or may not take for them.
Q Would you agree that most battered women who deny that they're battered, that the best thing for them is

to seek professional help?
A Sometimes that's true. There are programs for battered women that are very useful for them, but there are also women that need to come to it at their own time period, that many women or as most women believe that they can somehow save a relationship and I believe that each woman needs to have the dignity of being able to use that period of time to come to whether or not she needs counseling. Most men who batter [59] women are in need of enforced treatment and, indeed, the criminal justice system has now changed dramatically and has moved to that kind of mandatory counseling for men who batter women, to take responsibility for the abuse and to stop their violence when assaults are reported to the police. That tends to be the more effective sentencing for many of these men who are convicted of assaults.
Q At some point for a battered woman, if she's going to recover, she's going to have to acknowledge that she is indeed a battered woman, isn't that correct?
A Well, no, not necessarily. She needs to become safe from battering and that tends to be, once we can provide safety for a woman from being battered, many women do recover spontaneously. In fact, that's the whole, one of the major differences of a post-traumatic stress disorder diagnosis from other kinds of mental health disorders that are listed in the DSM-3R system is that we are taking an essentially normal, healthy person and placing them in an abnormal situation and when you remove the fear of further trauma from the abnormal situation, but simply time alone may be sufficient to reduce the symptomatology and stop the disorder, which is a quite important distinction between the PTSD and other kinds of diagnoses.
Q And most women that break out of this cycle of violence and learned helplessness then, would you agree

that for most [60] women that counseling is the best thing for them?
A No, not necessarily. Many battered --
Q Just -- just get out of the relationship and they'll just be better; they don't have any psychological problems?
A Many women simply do not. Now, the problem is that just getting out of the relationship does not terminate abuse.

As I testified earlier, the probability of a woman being more seriously hurt or actually killed increases when she gets out of and terminates the battering relationship, and so that is a real problem for keeping battered women safe. Once they get past that two-year period, if the man stops stalking, if the courts -- and generally we need the assistance of law enforcement and the courts to stop his abusive behavior towards her and the children -- then most battered women spontaneously heal.

Now, some women go into a battering relationship already having some psychological difficulties. Those woman, those problems won't go away and they may be the ones who need counseling, and so I spend a good deal of my time professionally trying to train professionals as how to differentiate between those women who are in need of counseling and those women where the symptoms spontaneously disappear.
Q Are you aware of any spousal notices that are currently in effect in the United States?
[61] A No, I do not.
Q Do you know of any that have been in effect in the United States?
A I'm not personally aware of them, no.
Q So there is no hard data out there to know whether a battered woman would avail herself of any exceptions to the spousal notice provision, isn't that correct?
A Not specifically about a spousal notification

provision--

* * *

Q Would you agree that there is some evidence out there to demonstrate that some women who receive -- some women that have an abortion do suffer from anxiety or depression afterwards as a result of having the abortion?
A I'm aware that --
Q Can you answer yes or no?
A No, I can't answer yes or no, it's --
[62] Q You don't agree that there are some women out there that have an abortion, experience anxiety or depression afterwards?
A There are some women where we know that they have experienced anxiety or depression, there is a small number of women, but there is no -- they are not in a post-abortion syndrome.

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RE-DIRECT EXAMINATION

BY MS. KOLBERT:
Q Now, Ms. Mershimer asked you whether or not there are women who suffer from anxiety or depression as a result of the abortion. You would agree, would you not, that there are some women who suffer anxiety or depression following an abortion?
MS. MERSHIMER: Objection; leading.
THE COURT: Overruled.
THE WITNESS: Yes, that is true.
BY MS. KOLBERT:
Q Do you have an opinion about whether or not those women [63] are suffering from anxiety or depression as a result of the abortion?

A Yes, I do have such an opinion.
Q What is that opinion?
A Well, based on my review of the literature and the most, the latest, the most recent article that was published in Science Magazine, which reviews all of the empirical data, that small percentage does not have the kind of syndrome that would be classified under a post-traumatic stress disorder, that those women, that there is a small number that do suffer from a depression, that there is a small number that do suffer from an increase in anxiety, but not in the syndrome, the way that we would use the PTSD criteria.

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DIRECT EXAMINATION

BY MR. ZEMAITIS:
[65] Q Now, Ms. Roselle, would you describe the process that a woman who comes to Women's Health Services for abortion goes through, the various steps of that process?
A Her first contact with the clinic would be by telephone where she would call in for information, and she would either come in for a pregnancy test or she would indicate that she had already had a positive pregnancy test and she would make an appointment. And during this telephone interview which lasts 20, 30 minutes, she would be given a lot of information [66] about the clinic and how to prepare for her surgery.

Within a few days the appointment occurs, most women can be scheduled within the week. She arrives at the clinic, she signs in, she has a confidential interview with the receptionist where her -- the chart that she has already started to complete is reviewed and her medical history, as she has completed, is reviewed for accuracy.

If -- her next step is the laboratory where the

pregnancy test is repeated, at which -- after which if the pregnancy test is indeed positive, she is either directed to counseling or she is directed for a sizing and a sonar. If she is directed for sizing and sonar, then she has counseling afterwards.

Following the counseling, which includes the informed consent process, the procedure is performed. She proceeds to the recovery room where she undergoes medical monitoring and she receives additional counseling on her care after she goes home, her future contraceptive plans, and then she is discharged.

Q You said that women sometimes come to Women's Health Services not yet having had a pregnancy test?

A That's correct.

Q And they have a pregnancy test at Women's Health?

A That's correct.

Q In those instances would a woman have an abortion, if she [67] chose to have an abortion on the same day as her initial pregnancy test?

A That would be highly unusual for someone to have a pregnancy test positive for the first time and have an abortion the same day.

Q Under what circumstances might that occur?

A Probably the only time that it would occur is if she were at such a point in her pregnancy that a delay of even 24 hours meant that she would have to go -- move from a 12-week to a 13, 14-week procedure or from that level to a second trimester procedure or perhaps not have the procedure at Women's Health Services at all, but she would have to be referred out of state.

Q I'd like to ask you some questions about the consequences of the Abortion Control Act on the operations at Women's Health Services, starting with the husband notification provision. Ms. Roselle, married women that come to Women's Health Services for abortions, are they accompanied by their husbands?

A Yes, they are.

Q What percentage, in your estimation, in Women's Health Services' estimation are accompanied by their husbands?

A 70 percent of the women are actually accompanied by their husbands.

Q And that's women that come to Women's Health Services?

[68] A That's correct.

Q Have you attempted to determine for those women who do not bring their husbands how many of them have notified their husbands or how many of their husbands know about the procedure?

A Another 25 percent of the husbands are aware that the woman -- of the pregnancy and her decision to have an abortion, so 95 percent of the husbands are either with their wives or are aware.

Q What are the reasons that the husbands don't come, even though they know about the abortion?

A Most often is that they have to work or that they have to provide child care while their wife is having surgery.

Q Now, for the five percent of the women who are not accompanied by their husbands and who haven't told their husbands, does Women's Health Services currently require them to notify their husband before they can have an abortion?

A No.

Q Why not?

A We feel that's an invasion of their privacy, if they make decisions, very sound decisions on their own and we would not intrude upon their decisionmaking.

Q Do women that don't tell their husbands tell Women's Health Services why they don't tell their husbands?

A Well, sometimes they do, yes.

[69] Q What kinds of reasons do patients at Women's Health Services give?

MS. MERSHIMER: Objection, your Honor, this is hearsay.

MR. ZEMAITIS: Your Honor, it's not introduced for the truth of the matter, but that this is what women report to Women's Health Services as those reasons.

MS. MERSHIMER: Your Honor, it's exactly offered for the truth of the matter. If they want to say that she's had conversations with women, fine, but then he's asking what did they say, it's for the very purpose of the reasons why women don't report or don't tell their husband.

THE COURT: Overruled.

BY MR. ZEMAITIS:

Q You may answer the question.

A If you could repeat the question?

Q The question is what reasons do women offer for not telling their husbands?

A They give a variety of reasons. Their husband may be ill and they don't wish to burden them with the additional stress of knowing that there has been a pregnancy within their relationship that, for example, one of our own counselors became pregnant while her husband was dying of leukemia and she chose to have an abortion and she chose not to tell him of the pregnancy. We have had women who have or a woman who [70] expressed her concern about her own health, that she had had three prior pregnancies, a lot of trouble with blood clots during those times. Her husband did not believe in the use of contraception. When the fourth pregnancy occurred, she knew that he absolutely was opposed to abortion, she made the decision to have the abortion without involving him because she knew that he would feel that it would be more holy of her to die than to sacrifice the fetus.

Q Any other categories of reasons that women give?

A That perhaps they -- that the pregnancy occurred when the marriage was failing, that marriage was already ending and there was a last attempt at reconciliation that didn't work and the decision not to have a child into -- as a single parent.

MS. MERSHIMER: Your Honor, may I have a continuing objection on all this testimony about what women have told her?

THE COURT: Yes.

* * *

Q The statute would require that a woman who -- all women who are married to fill out a form stating whether they have told their husband or, if they haven't, why they haven't. [71] Are you aware of that requirement, Ms. Roselle?

A Yes.

Q Does that cause any concern for you in your administration of Women's Health Services?

A Well, we'll now have to change our counseling to require women to tell us about some of the bases of their most intimate decisionmaking and that becomes a barrier between the care we provide and the relationship that we can establish with them because if they choose not to, what we're essentially saying to them is that if you choose not to tell us this or you choose to falsify this information, we're making you a criminal.

Q Do you have any concerns about the form being put in the files at Women's Health Services?

A Well, medical records, as we all know, in Pennsylvania are not immune from subpoena. And I had spoken to this before, before I actually had the experience when one of our records -- and I would like to add that I am the medical records custodian for

Women's Health Services -- one of our medical records was subpoenaed by the former husband of one of our patients. They were in a property settlement dispute, there was a property award made to her which was not followed through on, and he was subpoena her records saying that she had had an abortion in an attempt to discredit her and to prevent the property settlement, as agreed upon, to be [72] carried through.

Q Is your concern that a form in the file at Women's Health Services would be subject to subpoena and abuse as in that situation?

A It would become part of the medical record and under those circumstances, it could be subpoenaed.

Q Was Women's Health required to disclose the file in the case you just mentioned?

A No, we were not; the woman settled before the case went to court.

Q Ms. Roselle, I'd like to ask you some questions about the reporting requirements under the statute. Now, an individual induced termination of pregnancy form has been collected for the past two years. Have you been involved in the process of preparing those reports and submitting them to the Commonwealth?

A Yes.

Q Have you made any attempt to determine how much it costs Women's Health Services to keep up with that reporting obligation?

A Yes.

Q And what is the result of your estimate?

A It costs us $12,000 a year.

Q And how did you arrive at that figure?

A That is two-thirds of the clerical supervisor's salary [73] plus her benefits of 25 percent.

Q Do any other medical procedures that are performed at Women's Health Services require the submission of a form for each individual procedure?

A No.

Q Are you aware of any procedures performed in Pennsylvania generally that have the requirement of a detailed report for each procedure?

A No.

Q Does Women's Health Services receive any publicly allocated funds?

A Yes.

Q Under what circumstances?

A We receive medical assistance reimbursement for abortions provided for women who are victims of rape, incest, and we have the ability also if we would perform an abortion to ave[illegible]he death of a woman.

Q You say you have the ability, is that your testimony that that is not an instance, that you have not had instances like that where you have sought reimbursement?

A Not within the last year.

Q Have you sought reimbursement for rape or incest victims within the past year?

A Yes.

Q How many have you sought in the past year?

[74] A 46.

Q Is that number lower or higher than it has been in prior years?

A In 1988 it was 249.

Q What percentage of abortions performed at Women's Health Services are paid for by Medical Assistance payments?

A Less than one percent.

Q Approximately how many abortions are performed at women's Health Services during the year?

A Between 6500 and 7,000.

* * *

[76] Q Now, Ms. Roselle, are abortions ever performed at Women's Health Services on an emergency basis?
A Yes.
Q Under what circumstances?
A We have had women who have presented for an elective abortion who have been threatening to spontaneously abort and we immediately see them. If there is a physician available, we immediately see them and terminate the pregnancy right then.
Q I would like to ask you some questions regarding the [77] informed consent provisions and their effect on Women's Health Services. Dr. Allen testified yesterday that Women's Health Services does provide counseling to its patients. I would like you just to make it clear for the record what kinds of counseling are provided and when for an abortion patient at Women's Health Services.
A Okay. There are -- our counsel-- we have three types of counselors and the counselors are, we have personal counselors. These counselors would have at minimum a Master's degree in psychology, in social work. Our Director of Personal Counseling has a Ph.D. in counseling and a Master's in social work.

Personal counseling is specifically geared for the woman or the couple who are experiencing problems making decisions about a pregnancy. It may be that they are ambivalent, that the woman is feeling coerced, that the woman is under -- very sad because she has decided to terminate a planned pregnancy that is complicated by fetal anomalies that are incompatible with life after birth. These therapists, after they have completed their higher degree, must have at least five years experience before we will allow them to do problem pregnancy counseling.
Q How do you determine -- do all patients, abortion patients, go through personal counseling?
A No.

[78] Q How do you determine which women or women and their partners go into the personal counseling?
A There are two ways, and I can't say that one outweighs the other; they are equal. One is that by word of mouth, Women's Health Services has an excellent reputation in the Pittsburgh community as providing outstanding counseling services, and a lot of women simply call and say "I would like to see a counselor."

The second way is if that the woman are identified as having difficulties making decisions or difficulty, unusual difficulty or unusual ambivalence or the coercion factor has entered in by another type of counselor within Women's Health Services and then they are referred for personal counseling.
Q What is that other type of counseling?
A Well, the other type of counseling, to distinguish, their title is a paraprofessional counselor and these are what Dr. Allen referred to as the pre-abortion counselor, or the abortion counselor yesterday. And these women are trained by Women's Health Services to be health educators and also to be able to assess someone's capabilities of making decisions and whether or not they're comfortable with their decisions and whether or not what they are expressing is consistent with their, say their body language, with their affect, with their general demeanor within the counseling session.
[79] Q How are the paraprofessional counselors selected?
A Paraprofessional counselors must go through a rigorous selection process. They begin by completing an application with us and we review the application for some kind of exposure to counseling that they have conducted, and then once they pass the paper screening, then they are, between five to eight people are scheduled simultaneously for what we call a group interview. The group interview is essentially a two-hour problem solving

session where we give the applicant two problems that they must solve. One is a problem around sexuality, the other problem is a series of policies that if you were the Board of Directors of Women's Health Services, how would you handle these. And then we have two observers in the room while they are doing this problem solving and we select them, that we score them based on their attitudes towards contraception, towards sexuality, their ability to be supportive of each other without being competitive. We are looking for someone who has an innate ability to relate to other people. Once they get past that, then they go through an individual interview.

Q Is there any minimum age requirement, or excuse me, any minimal educational requirement for counselors?

A We require them to have a GED or a high school education.

Q During the course of the counseling by the paraprofessional counselors, does the counselor give [80] information for informed consent?

A Yes.

Q So that's not done by a physician?

A No.

Q Does the paraprofessional counseling occur for all women who have abortions at Women's Health Services?

A Yes.

Q And does it typically occur on the day the abortion is performed?

A Yes.

Q If the 24-hour waiting period goes into effect as required by the statute, what impact do you project it will have on patients of Women's Health Services?

A Well, they'll certainly experience a delay and I also feel that they're going to have increased expenses. I'd like to expand a bit and talk to you about where our patients come from, we serve women from 34 counties

within Pennsylvania, from portions of Ohio, West Virginia, Cumberland, Maryland, you know, as far east as Cumberland, Maryland, and New York State, so we have a very large service area. And it is not unusual for women to travel three, four hours to get to the clinic. Sometimes it's much longer because they have to take buses to get in.

Q So that 24-hour -- typically the counseling and abortion occur on the same day?

[81] A That's correct.

Q So that if there were a 24-hour waiting period, there would have to be two visits to accomplish those two goals?

A That's right.

Q The statute, as I think you know, Ms. Roselle, also has a provision requiring parental consent and it requires informed consent for parents. Some of the physicians who testified yesterday said they did not think that informed consent could occur by telephone or by a form. Were you here for that testimony yesterday?

A Yes.

Q Do you agree with that testimony?

A Yes.

Q What effect would it have on minor women who seek abortions at Women's Health Services if both parents had to come in for counseling and the 24-hour waiting period were to go into effect?

A Well, what we get is layer of -- layers of obstacles that the teenager, the minor would have to experience and it -- and the more parts of the law that become -- go into effect,the deeper the layers and the greater the obstacles. If you talk about a 24-hour period, we're talking about delay and additional costs. If we're talking about parental consent, we're talking about additional delay. If we talk about with a judicial bypass, it's still more delay, more expense, more [82] trips to the clinic.

And then if we talk about physician doing the -- conducting the informed consent portion of 24 hours in advance, then it becomes even more difficult and even more layered and that's particularly true of a young woman.

Q Would it be possible if the 24-hour waiting period went into effect for Women's Health Services to guarantee that there would only be a 24-hour delay for each woman seeking an abortion?

A No, we could not do so.

Q Why not?

A We don't have physicians available to us every day of the week, other -- in the clinic, so therefore we would not be able to conduct the informed consent interviews every day.

* * *

[83] Q Do you believe it is consistent with the counseling process at Women's Health Services to insist that all the information in the statute be given to all patients?

A No.

Q Why is that?

A Not all the information that the statute requires is relevant to all patients.

Q Could you look at -- go to the other binder and look at the last tab, which is a copy of the act, and turn to Page 8 which has the specific information required by the informed consent provision?

At the bottom of that page there is a mention of [84] Medical Assistance benefits may be available for prenatal care; do you see that?

A Yes.

Q Is that information that is given to all women who come to Women's Health Services for an abortion?

A No.

Q Why not?

A Because it's not relevant to all women who come to Women's Health Services for an abortion.

Q Ms. Roselle, do you have any personal experience in counseling?

A Yes. I was a social worker in a family planning clinic in the early 70's in Norfolk, Virginia.

Q If you were required to give information as a counselor that is not relevant to the person you are counseling, what impact do you think that would have on the counseling process?

A Well, it interferes with the counseling relationship because people don't under-- they don't understand where it's coming from and they also think that you're not listening to them.

* * *

[85] Q On Page 9 there is a provision that requires that the father of the unborn child is liable to assist in the support of the child. Is that information that Women's Health requires to be given to all women at present?

A No.

Q Why not?

A Because it's not relevant.

MS. MERSHIMER: Objection, your Honor; same basis, lack of foundation. Ask that the witness' answer be stricken.

MR. ZEMAITIS: Your Honor, I don't think this is without foundation. Ms. Roselle knows the protocols at Women's Health Services and she knows the reason for them.

THE COURT: Yes, I think there's an adequate foundation; overruled.

BY MR. ZEMAITIS:

Q Now, Ms. Roselle, are you also aware that the

department will be required to make available to a clinic such as Women's Health Services certain printed materials?

[86] A Yes.

Q Have you had an opportunity to review any of those printed materials?

A Yes.

Q What was the first opportunity you had to do so?

A Yesterday afternoon.

Q I would direct you to the document that is behind Tab 49.

MR. ZEMAITIS: In the defendant's exhibits, your Honor, I'm sorry. This is the document we added to this morning. Defendant's 49.

Your Honor, I will represent for the record that this document was presented -- the first page of this document was presented to us last Friday by counsel for the defendants and the remaining pages were presented to us yesterday at the beginning of the hearing and it's my understanding that this is a version of the printed materials or part of the printed materials that will be offered under Section 3208 of the act and will therefore be required to be at clinics for distribution under Section 3205. And with that basis and representation, I would like to ask Ms. Roselle some questions about it.

BY MR. ZEMAITIS:

Q Have you had an opportunity to review this list -- this directory of social services organizations, Ms. Roselle?

A For Allegheny County.

[87] Q You paid particular attention to Allegheny County because that's where you're located?

A That's correct.

Q Do you have a general familiarity with the social service organizations that are available in Allegheny County to help women and children?

A Yes, I am a convener of a group called the Women's Service Providers, which is the executive directors of the women's service agencies in Allegheny County. I am also Chair of the National Association of Social Workers for Southwestern Pennsylvania, so I do have a great deal of familiarity with social agencies.

Q Now, the listings for Allegheny County begin on Page 3 of the page numbered 3 and continue to the page numbered 6. In your review of that list, did you notice any omissions of agencies that you think would be appropriately included on that list?

A Yes. Family Health Council is not included on the list. Family Health Council is the umbrella agency for all the family planning clinics in Western Pennsylvania and I believe they have about 40 counties. They also provide adoption services and they provide prenatal care.

Another exclusion would be Women's Health Services, Planned Parenthood and Allegheny Reproductive Health Center. The fourth abortion clinic in Allegheny County is on this [88] list, so therefore I would speak for the rest of us.

Q Would you tell us what that fourth clinic is?

A Yes, Allegheny Women's Center.

Q And that appears on Page 4 of the document?

A That's correct.

Q And to your knowledge Allegheny Women's Center provides abortions?

A I -- I am certain they do.

Q Does it provide services for women that Women's Health Services does not provide, to your knowledge?

A No, they do not.

Q And the other clinics you mentioned that are not listed are Planned Parenthood?

A Planned Parenthood.

Q And?

A Allegheny Reproductive Health Center. Another

very glaring omission in this is the Women's Center and Shelter. We only have one shelter for battered women in Allegheny County and it's not on this list.

Q Are there any institutions that are listed or organizations that are listed for Allegheny County that cause you any concern?

A Women's Health Services is very careful about where we refer. For example, we recently updated our referral list for adoption agencies and how we did that is we went and [89] visited every adoption agency in talked with them and found out their philosophy and then we established information to give to patients that we do give to them. We wouldn't -- this list has not -- some of the agencies on the list would not meet our criteria for an agency to which we would make referrals.

Q Can you give me any examples?

A Any of the Crisis Pregnancy Centers.

Q And why do the Crisis Pregnancy Centers, why are they not organizations that you could comfortably refer women to?

A Because we know from the literature that women have brought to Women's Health Services from the Crisis Pregnancy Centers that they give misinformation and disinformation with the sole purpose of dissuading someone from having an abortion. They simply want a woman to terminate a -- or to continue a pregnancy.

Q So absent the requirement that that organization is on the State's list and you have to give it to women, you wouldn't use those as referral agencies from Women's Health Services?

A That's correct.

Q Now, turning back to the other mandated provision in the statute which are the -- you don't even have to have it in front of you, but the availability of assistance, Medical Assistance benefits and the fact that the father is liable [90] for support of the child, do you have any

concerns as to the accuracy of that information when it is appropriate for women?

A I'm trying to --

Q If Women's Health Services were required to tell all of its patients that the father is liable for the support of the child, do you have any concerns about whether that would be useful information for Women's Health Services patients?

A Well, first, half of our patients, our abortion patients are married, so we certainly wouldn't say that to half of our patients. The other half of the patients, if there was an indication that financial problems were the sole reason that someone was having an abortion, the paraprofessional counselor would refer the woman for personal counseling. And during the personal counseling session, support of the alleged father would be discussed. And the women, if that was an area in which she chose to explore, then a referral to perhaps Legal Aid or Neighborhood Legal Services -- neither of which are on this list either -- would be made.

But it's so infrequent that someone would say that the sole reason they're having an abortion is economic that it's very rare that we would do that. So it's just, it's simply not relevant for the vast majority of women and to be required to do it holds out false hope to these women.

Q In your experience as a counselor, Ms. Roselle, what is [91] the purpose of counseling?

A The purpose of counseling is to help -- help anyone, regardless of their age, make decisions, to discuss, to identify what their options are, to discuss the pros and cons of each option and to reach a decision and to utilize all of the resources of themselves, their community and their support system in making that decision.

Q Is it the obligation of the counselor to try to persuade the person he's counseling to one or another

position?
A It is their ethical obligation not to try to dissuade someone.
Q Now, Dr. Allen yesterday discussed the fact that pictures of fetal development are available at Women's Health Services if any patient wants to see them. Is it a routine part of the counseling process to offer women the opportunity to review those pictures?
A No.
Q Under what circumstances would a woman be offered that opportunity?
A When she requests to see the level of fetal development.
Q If a woman requests to see those pictures, how would the pre-abortion counselor react or the paraprofessional counselor?
A It's usually posed by a woman who has been to a Crisis Pregnancy Center and gotten some inflammatory literature or [92] has been exposed to a movie called "The Silent Scream" and then she wants some factual, scientific information. It is also a very clear indication of her ambivalence and she is not, she's not immediately given surgical services, she is offered and referred for personal counseling.
Q Now, insofar as the parental consent provision of the statute is concerned, are there instances today where minors come to Women's Health Services, saying that their parents know about the pregnancy but that they refused to accompany them?
A Yes. In a case that I was personally involved in was a 14 year old from a very rural area about 75 miles from Pittsburgh. The physician made the referral directly to me because we have mutual acquaintances and this young woman, when she became -- when her family became cognizant of the pregnancy, she was shipped off to live with the sister who was 19 and a single parent,

and the -- her 15 year old boyfriend was forbidden from seeing her. After a couple of weeks of living in her sister's household, she decided that she needed to have an abortion, that this at 14 was not the lift that she wanted to look forward to, and so she convinced her boyfriend to walk to a rural health center where she was counseled by a physician. And the physician called me and said, you know, "They're 14, she's 14 and he's 15, and we've got about a week left for a first trimester abortion and they [93] don't have any money," and I immediately approved a grant from what we call our Vivian Campbell Fund, so there would be no fee, no charge to the patient, and then the problem was how do we get them there, because neither of them was old enough to drive but they were about to be parents. So we convinced or she convinced her 16 year old brother to make his first trip into the City of Pittsburgh, and if you live in rural areas, you understand that sometimes super highways are overwhelming for -- for even adults. So this 16, 15 and 14 year old came in and the young woman had her abortion, and the 16 year old brought the news that now that the pregnancy was terminated, the young girl was allowed to return to her parents' home. So that's when she left the clinic, she was able to return home.
Q Ms. Roselle, has Women's Health Services been the target of activities by opponents of abortion?
A Yes.
Q How long; for how long a period?
A For 17 years, since the day we opened.
Q Have the employees of women's Health Services been the target of activities by opponents of abortion?
A Yes.
Q And has that continued up to the present?
A Yes.
Q How about patients?

[94] A Yes.
Q And does that also continue up to the present time?
A Yes.

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[95] Q In the past year has there been any change -- I'm sorry. The question I had asked you and you had not had an opportunity to answer was to describe the kinds of activity.
A Well, they -- with -- beginning with 1986 --
Q That's when you came to Women's Health Services?
A That's when I -- when I started. There are leafletters almost every day, picketers on Saturday, some what was referred to as sidewalk counseling. One of our doctors' home was picketed, my home was picketed with, I came home on a beautiful Sunday afternoon after having been to a horse show with my daughter where she won her very first best of show, it was a wonderful family day to coming home to "Sue Worstell" -- which is my married name -- "is a murderer. [96] This home was bought with blood money." Then -- that was a very difficult day, I'm sorry, I didn't really mean to tell that story. My daughter was subsequently a target of a kidnapping threat where -- which was turned over to the FBI. She was 16 at the time, which was a kind of a time when she was feeling real independent, so we had guards at the house for a period of time and she wasn't allowed to go home after school by herself, things like that.

We have seen a great escalation in the kinds of harassment of all of the clinic employees of our patients and really of the building owners, too, beginning in September of 1988. Prior to that, Operation Rescue had come to Pittsburgh, but in September of '88 we were a target, Women's Health Services, targeted the Fulton Building and there were over 600 people at a

demonstration and there were 370 arrests that day.

We have also in September of '89 there were four people who forced their way into the clinic with -- behind an employee who was coming to work, with buckets of roofing tar, and they positioned themselves with their feet in the roofing tar and during the subsequent arrests, the tar was spilled in our main patient care area. The --

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[98] Q Now, since this tarring episode, have there been any major demonstrations?
A Well, we have become the target of a group called "Project Multitude," and they have had three demonstrations at Women's Health Services. The first one was in February that they had 1200 people there, where they -- they were [99] there for five hours and they sang and had speakers and generally had a very peaceful demonstration. People could get down the street, women could get into the clinic and there was no problem. In April there was about half that number, there were about 600, they were much more aggressive, they were much more taunting and abusive towards anyone who was walking down the street. We had a number of complaints afterwards, there were a number of our patients gave written documentation about the harassment that they encountered and for the first time ever in the existence of Women's Health Services did women actually say I will not go through that mob and I want to reschedule an appointment. And so that was the first time.

In June the -- they came back again and there were 450, according to the police, and the police cordoned off part of the sidewalk for an entire block and put the demonstrators on part of the sidewalk and part of the street, and there was actually a clear pathway for people

to go down the street, which on first blush sounds fine, and it really, people could actually get access to the building. The problem was, was that the police also refused to allow women to be escorted, so the whole time that they were walking in this open space, their photographs were being taken by both television cameras, from the media, from the press, from the anti-abortion demonstrators so that they had no privacy [100] whatsoever. I mean, I have been wont to say that after that situation, that women had more privacy when they were having illegal abortions than when they're having legal ones now.

Q Now, just to step back for a moment, you said after the tarring incident, were there repairs that needed to be made at Women's Health Services?

A Yes. The final tally on damages was in excess of $27,000.

Q In between these major demonstrations that you've mentioned, has regular picketing continued to go on at --

A Yes.

Q -- Women's Health Services?

A Yes.

Q You mentioned earlier, I think the term was sidewalk counseling. Does that continue today?

A Well, the sidewalk counseling is what they call it, but what the woman are -- they're really shouted at. And they're shouted at: "Don't go into that building, don't kill your baby, we love you, Jesus loves you and don't do these kinds of things." And they're followed down the street and they act-- they -- the demonstrators actually hold open the door and shout into the lobby of the building after the woman.

Q Has the character of the sidewalk counseling changed in the past few years?

A Oh, yes, it's become much more aggressive. It's not just [101] a matter of handing a leaflet and saying "We

have services that can help you. This is very aggressive and it's not reaching out anymore.

Q Has Women's Health Services or its staff been the victim of threats in the past year?

A Yes. We ran an advertisement, it was not -- it was an educational piece, but because of the controversy around abortion, we had to pay for space in a newspaper. And when the educational piece came back to us, to me one day, and in purple ink was written across it: "I will personally kill one of your staff by June -- one of your employees by June 15th."

* * *

[102] *CROSS-EXAMINATION*

BY MS. MERSHIMER:

Q Ms. Roselle, is a positive pregnancy test required prior to a woman being able to schedule an abortion at Women's Health Services?

A Yes, it is.

Q So she can't even come before she has had one?

A She can come for just a pregnancy test, but we don't make abortion appointments until she's had a positive pregnancy test.

Q And from what you've testified this morning, there are some unusual circumstances where a woman will have a pregnancy test on the same day that she'll have the abortion?

[103] A Yes.

Q But usually it's she comes back another day then for the abortion?

A Yes.

Q And she comes back another day for the counseling?

A No.

Q So there's occasions when she'll come in, have a pregnancy test and have a counseling for an abortion and

then come back a different day for the abortion?
A I'm sorry.
Q Okay, yeah, I want to be clear.
A The -- what -- she would have the pregnancy test. She would ask to see a counselor. She would, during the face-to-face with the counselor, she would receive the information-- this is a paraprofessional counselor -- that she would normally receive over the telephone, had she called to make an appointment, she would receive her appointment. Then she would come back on another day and receive the pre-abortion counseling, informed consent and the surgical services.
Q And what is the information that the paraprofessional counselor gives the woman?
A At what time?
Q Right, well, let's back up. You said normally a woman, if she comes in for a pregnancy test and the counseling on the same day, the paraprofessional would give --
[104] A I --
Q The paraprofessional would give the woman the information that normally would be provided in a telephone session, is that what you said?
A Yes.
Q Okay, what is the information that is provided in that telephone session?
A To the best of my recollection, okay?
Q Right.
A The -- the date of her last menstrual period, the -- her decisionmaking, what kind of support system she has, what alternatives she's investigated and then information about the preparing for the abortion, what to wear, what to eat prior to coming in, whether or not she is going to have intravenous sedation, various things. Does she have any known allergies, does she have any preexisting medical conditions that would be contraindicated to the

service and her arrangements for financing.
Q If the woman, the patient would ask -- is this a telephone counselor, is that a fair name for her, or --
A Well, it's the paraprofessional counselors and our nurses rotate in the telephone room and in the clinic, so --
Q Okay.
A -- call them a counselor.
Q All right, well, at least during the telephone session?
[105] A Mm-hmm.
Q If the woman on the phone, the patient, would ask for information about the risk of the procedure, would that be provided to her then?
A Oh, yes.
Q And you said these sessions tend to last from 30 to 40 minutes when there's a telephone counseling session?
A It varies. I would say 20. I'd say -- I think I testified 20 to 30.
Q Okay, 20 to 30. From what you've just said, it's either nurses or paraprofessional counselors that man the phone, is that right?
A Mm-hmm.
Q How many people do you have manning the phones on any given day?
A Five.
Q And what is the paraprofessional's salary?
A I believe their beginning salary at this point in time is $7.80 an your.

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[109] Q Do you recall making a verification in this case on April 18th, 1988?
A Yes.
Q Or thereabouts? And you recall making the statement that "The great majority of our patients have

absolutely decided to have an abortion before seeking medical care"?
A Yes.
Q Can you tell me the basis of that statement, how you know that?
A Well, I know that most of the women who go through pre-abortion counseling are not referred for problem pregnancy counseling because they are not ambivalent, they are not conflicted, they are not being coerced, they have made this decision. They don't request problem pregnancy counseling.

* * *

[112] Q Now on July 20th, 1990, the Philadelphia Inquirer quoted you as saying, quote, "We've certainly found an increase in pre-abortion anxiety. There are more questions that indicate people have heard the propaganda, is it really murder, does it have little toes, can it feel pain. We know if they've had a pregnancy test at a Crisis Pregnancy Center that they will have a lot of misinformation."
Is that an accurate quotation?
A I've never seen that article.
Q Is it --
A Could I see the article?
Q Certainly.

* * *

[113] Q Could you tell us, ma'am, is that an accurate quotation?
A That's part of a quotation.
Q Is that part that was quoted, is it accurate?
A As -- as I recall, yes.
Q Now, if a woman who is nine weeks pregnant and

asks a counselor whether the fetus has hands and fingers, would she be told yes, that's correct?
A No.
Q Why not?
A A counselor is not qualified to answer that kind of question.
Q Well, would she be referred to photographs or any sort of literature?
[114] A She'd be referred to the personal counselor.
Q And then would the personal counselor provide her with photographs and literature?
A If that's what she asked to receive. The other thing that might occur is a physician would be called in.
Q If a woman asks about alternative facilities that would help her carry a child to term, is she provided that information?
A Yes.
Q And if she asks questions about assistance benefits, is she referred to an agency that can address that?
A She's referred to the Department of Public Welfare in the county in which she resides.
Q And I think you testified that if a woman asks about whether a father might be liable for a support payment, she's referred, given information about that?
A Uhm, yes.
Q What materials does Women's Health Services provide a woman considering options to abortion such as adoption?
A Well, she receives -- she receives personal counseling and then based on what her situation is and what her desire is, she's referred to a licensed abortion -- or adoption agency within the county in which she resides. That agency, for example, if she is Roman Catholic she will probably be referred, at her request, to Catholic Social Services or the [115] Roselia Home. If she has no religious preference as to an adoption agency, she may

be referred to the Zoar Home or to the Children's Home. It depends on what her situation is.
Q And what materials do you provide a woman, if she asks for it, about prenatal care?
A Well, the materials that we provide about prenatal care depends on where she lives and whether or not she has private insurance that will pay for prenatal care and delivery.
Q I'm not sure if you fully answered my question, so --
A I'm sorry.
Q So what information do you give them about prenatal care?
A Well, if they -- if they do not have private insurance, if they're going to be on medical assistance, there is no private provider that will take care of medical assistance patients in Allegheny County. And in fact, in some of our counties, women can't get prenatal care and be on medical assistance at all. So therefore, we have a problem.

And if they are on medical assistance, they have to go to a clinic. And if they live in the wrong county, then they go to -- sometimes the Family Health Council can handle them and sometimes a physician, out of the goodness of his heart will, you know, take a limited fee, but will not accept medical assistance.
Q Now prior to performing an abortion at Women's Health Services, is the woman or patient told the gestational age of [116] the fetus?
A Yes.

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[117] Q I'm not sure if I asked you this question. How many doctors perform abortions? I know you have abortion services [118] provided three days a week. How many doctors do you have working each day?

A Either two or three.
Q And how many doctors are contracted -- you contract with the doctors; right?
A Yes.
Q All right, how many are contracted with Women's Health Services all together?
A Right now we have 13.
Q And those three days that abortions are provided, is there a time frame that the abortions are provided, is it like 8 to 5 or 12 to 8; do you know?
A Yes, there is a schedule. The first appointment is at 7:45.
Q Till when?
A 12:30.
Q P.M. or A.M.?
A P.M.
Q That's for each day?
A Yes.
Q And that's -- I mean, just so I'm clear, that's the period of time that the abortions are actually performed?
A I'm sorry. I apologize, those are the appointments. Abortions, the clinic actually begins, as far as the surgical procedures start, between 9 and 9:30 and depending on the [119] number of appointments and the number of physicians available, they end between 4 and 4:30.

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Q I just want to see -- to have this straight. You had said that the cost to keeping up with the reporting [120] requirements for the Department of Health were about $12,000 a year?
A That's right.
Q And you said that was two-thirds of the clerical employees salary?
A That's correct.

Q And that's because you took the clerical employee's salary and had her do some of the work of your medical director so the medical director could fill out the forms for the Department of Health?
A Yes.

* * *

[121] Q Now you said, am I correct, that acts of harassment or protests against Women's Health Services have occurred since the day the clinic opened?
A Yes.
Q And that was 17 years ago?
A Yes.
Q And it has continued on periodically ever since then?
A And it escalated in September of '88.
Q And it's -- and you've had these acts all the way through the period of time that the 1988 and '89 amendments have been enjoined; that's correct?
A And they've continued to escalate.
Q Now we've talked a lot about Plaintiff's Exhibit 6, Women's Health Services' medical form.
A Mm-hmm.
[122] Q And page 11, being the informed consent form?
A Mm-hmm.
Q That's the only form of consent form that there is; right?
A Yes.
Q You don't have a different in cases of rape, incest or battered women?
A There are different forms for women who are rape and incest victims to complete, but they aren't part of -- informed consent.

* * *

[124] Q When we were talking about Defendant's Exhibit 49 this morning, you said that there were some agencies that were omitted from the list of providers?
A Yes.
Q Is there anything prohibiting you from telling the Department of Health that some agencies have been omitted and should be added to the list?
A No.
Q Is there anything to prevent Women's Health Services from supplementing the Department of Health's list?
A I don't know.
Q Is there anything that prevents counsellors from offering their opinion about additional providers other than is on the list?
A I don't know.
Q Now when you were talking about whether information would be provided to a woman about a father being liable for support payments, that that information would be provided in cases where that was the sole reason the woman was offer for the reason to have an abortion?
A Yes.
Q Now if the woman would say that was just one of her [125] reasons, not necessarily the sole reason, would she still be provided that information about the father --
A Yes.
Q -- giving support?
And are you familiar -- wait -- and you said that this very rarely happens that a woman's concern -- sole concern is that there's not enough money?
A That's right.
Q Is it more frequently that that's a partial factor, however?
A That's correct.
Q And are you aware of any -- do you know what the

Family Planning pregnancies -- I mean Perspectives is?
A Yes.
Q Could you tell me?
A Family Planning Perspectives is a journal that's published by the Alan Guttmacher Institute.
Q And are you aware of any recent studies by Family Planning Perspectives that establishes that about 20 or 21 percent of the women who have abortions, that one of the reasons they have an abortion is they don't feel they can afford the baby?
A I read Family Planning Perspectives every other month cover to cover and I don't know that direct quote. If it's from the article that I testified about in my deposition [126] before, I just can't remember that it was 21 percent. It sounds familiar.
Q Does that sound about right in your experience at Women's Health Services?
A I don't know.

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Q Ma'am, do you recall when I asked you if a woman asked who had a nine week old -- she was pregnant nine weeks gestational age and if she asked the paraprofessional counsellor if the fetus had hands and fingers whether she would be advised yes, she was and you said no, because she would be referred to the personal counselor?
A That's correct.
Q Would the personal counselor tell her yes to that question?
A Possibly. I think that -- and I'd like to qualify my response just that I haven't done problem pregnancy counselling in a lot of years -- about 17. But the protocol would be that she would explore the reason for her question. And if the -- because questions like that

come out of [127] ambivalence about whether this woman really wants an abortion or she wishes to continue the pregnancy. And that may be the real issue.

But if the issue is truly that she wants to know that piece of information and a drawing or a photograph would be helpful to her, then she would be offered that opportunity.

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[128] Q Now we had a discussion about telephone counselling at the beginning of your cross and I want to make sure the record is clear on that. Women who have pregnancy tests other than at Women's Health Services, when they first contact Women's Health Services, it's to set up an appointment for an abortion; is that correct?
A Yes.
Q During that conversation, would they have telephone counselling?
A Yes.
Q And that's the telephone counselling where you describe the series of information that would be asked or obtained from the woman?
A Yes.
Q How long does that process typically take?
A 20 to 30 minutes.
Q And the woman who comes in to Women's Health Services for a pregnancy test and wants to set up an abortion appointment at that time would get that same -- the same information as the telephone counselling?
A Yes.
[129] Q But that would occur on site?
A That's correct.
Q Now that's not a substitute, is it, for the pre-abortion counselling that takes place on the day of the procedure?
A Oh, absolutely not.

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[143] MS. MERSHIMER: Your Honor, the Commonwealth would call Dr. Vincent Rue.

VINCENT M. RUE, Defense Witness, Sworn.

MS. MERSHIMER: Your Honor, Dr. Rue's curriculum vitae is Defendant's Exhibit 62. To summarize, as the Court has requested, Dr. Rue has a B.A. Cum Laude from St. John's University, 1970, in Sociology. He has a Masters in Social Work from St. Louis University in 1972 in Clinical Social Work. He has a PhD from the University of North Carolina at Greensboro in 1975 with a major in Family Relations and a minor in Sociology. In early 1990, he was co-founder and co-director of the Institute for Abortion Recovery and Research in New Hampshire. In 1975 through 1990, he was the Executive Director and also Psychotherapist and an individual marriage and family therapist at Sir Thomas Moore Clinic, Downey, California. From 1975 to 1980, he was Associate Professor of Family Relations in the School of Fine and Applied Arts, California State University at Los Angeles. He is also an adjunct Associate Professor at the School of Professional Psychology, United States International University, San [144] Diego.

He has numerous professional associations. He's provided consultation and written articles regarding adolescent problem pregnancy decision making, problem pregnancy decision making, spousal notice and informed consent and the psychological effects following an abortion. And he has presented a number of presentations on these topics.

DIRECT EXAMINATION (VOIR DIRE)

BY MS. MERSHIMER:

Q Dr. Rue, you're a licensed marriage and family therapist and trained psychotherapist; is that correct?

A Yes.

Q Could you explain that?

A I am licensed in the State of California as a marriage and family therapist. I work with individuals who present with a variety of problems, from anxiety disorders to depression, et cetera. I work with marital units, husbands and wives who express difficulty in one way or another with communication and sexual dysfunction, et cetera.

And I also work with families who have experienced distress and provide therapy for them. I have had training in the area of psychotherapy, which is really more advanced and more in depth work than general counselling. And that is primarily what I have done in the last 15 years in [145] California.

Q Do you clinically treat individuals with emotional and/or mental problems?

A Yes, I do.

Q And how long have you been doing that?

A I've been doing that as a licensed therapist for 15 years in California. And prior to licensure, an additional three years.

Q Okay, now while employed at Sir Thomas Moore Clinic, what types of counselling services did you provide?

A I provided personally individual counselling, individual psychotherapy, psychological assessments, as well as group therapy, conjoint marital therapy, conjoint family therapy, crisis pregnancy counselling and post-abortion counselling.

Q When you say post-abortion counselling, did you begin to develop a specialty in that area?

A Yes, I did.

Q Could you explain that specialty?

A The area of post-abortion counselling and post-abortion trauma in a relatively new area. It, in

essence, focuses on the painful aftermath that some women and men feel after experiencing an abortion. It's characterized by the unwanted, undesired --

MS. KOLBERT: Your Honor, I would object as to the substantive aspects of this in that counsel for plaintiffs do [146] have some questions as to voir dire.

THE COURT: Yes, are you qualifying the witness at this point?

MS. MERSHIMER: I was attempting to, your Honor.

THE COURT: Well, we're concerned with his qualification, not with the substantive aspects of his testimony. You may wish to limit it in that manner.

MS. MERSHIMER: I apologize, your Honor.

THE COURT: And then tell me the field of his expertise.

BY MS. MERSHIMER:

Q Could you tell the Court how many women you've provided psychological,counselling for in problems occurring after abortions?

A I would say hundreds.

Q And have you counselled women before they've had an abortion?

A Yes, I have.

Q And could you tell me the number of those?

A Again, in the area of hundreds.

Q And have you counselled men who have experienced difficulties following abortion by their wife?

A Yes, I have.

Q And could you tell me the number of men in that area?

A At least over 100.

[147] MS. MERSHIMER: Your Honor, I would offer Dr. Rue as an expert in psychological effects following abortions, problem pregnancy decision making with abortions and marital family relationships.

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CROSS-EXAMINATION (VOIR DIRE)

BY MS. KOLBERT:

Q Dr. Rue, it is true that you're not a psychologist; is that correct?

A That's correct.

Q And it's also true -- let me ask you to turn to your curriculum vitae, which is in the notebook in front of you under Defendant's Exhibit 62 -- no, I'm sorry, it's the manilla notebook.

Sir, it's not -- that's the plaintiff's exhibits. It's the Defendant's Exhibit Number 62.

A Okay.

Q Did you prepare your curriculum vitae?

A I did not type it, no.

Q But you did prepare it and examine it before sending it to plaintiff's counsel?

A No, I did not.

Q Did you examine it before sending it to plaintiff's counsel?

A No, I did not.

[148] Q Is this a vitae that you use in other instances besides court appearances?

A This is my vitae, but it was sent from my Los Angeles office and I am in New Hampshire at this point.

Q Now I direct your attention to underneath the -- it is correct that you -- I'm just a little confused about your PhD. Did you receive a PhD in family psychology as your vitae reports?

A No, it should be listed as family relations, which is what counsel just previously --

Q And that is, as I understand it, from the School of Home Economics at the University of North Carolina?

A It's from the School of Home Economics, Department of Child Development and Family

Relations.
Q But the PhD is a home economics PhD with a major, as you've described in your resume, in family relations?
A No, I don't believe that that is accurate. It is not a PhD in home economics, it is a PhD in family relations. In the Department of Child Development and Family Relations, there was a joint specialization or an individual specialization.
Q Okay.
[149] A Mine is in the area of family relations.
Q But you would agree that the degree was granted by the School of Home Economics?
A No, that is not correct. The degree was granted by the Graduate School of the University of North Carolina.
Q I would like to -- so you're saying that there's no home economics degree at all?
A There certainly are, yes.
Q But your's was not a home economics degree?
A That's correct.
Q I'd like to show you the commencement report from the University of North Carolina at Greensboro in 1975.

MS. MERSHIMER: Your Honor, could I see this exhibit?

(Pause in proceedings.)

BY MS. KOLBERT:
Q Can you read for me the -- what is next to your name under Candidates for Degrees?
A It says Home Economics. I've not seen this before and I was not present at my graduation.

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[151] Q Have you ever performed informed consent counselling or offered informed consent counselling in any way?
A With respect to what?

Q With respect to women seeking abortions?
A I have provided crisis pregnancy counselling.
Q No, my question is it's true that you've never proved informed consent counselling, that is, obtained a woman's informed consent prior to the performance of abortion?
A Well, counsel, because I'm not a physician, I don't think I could do that.
Q And it's also true that you've had no experience counselling women in Pennsylvania who have obtained -- who [152] have given informed consent for abortions; is that correct?
A That is correct.
Q And it's also true that you've never conducted any independent research about informed consent counselling within Pennsylvania abortion clinics; is that correct?
A That's correct.

MS. KOLBERT: Your Honor, plaintiffs would object to any testimony by this witness as to informed consent and informed consent counselling. We have no problem with him being certified as a marriage and family therapist and an expert in family relations, but that that would not go to testimony as proffered by the Commonwealth as to his expertise in informed consent in that interchange.

THE COURT: All right, Ms. Mershimer, do you wish to ask any further questions or make any comment concerning the objection? To qualify your witness in the area of informed consent.

MS. MERSHIMER: I would ask a few more questions, your Honor.

THE COURT: All right, why don't you proceed.

REDIRECT EXAMINATION (VOIR DIRE)

BY MS. MERSHIMER:
Q You say that -- you had previously said that you have provided psychological counselling for hundreds of

women [153] experiencing problems after having an abortion?
A Yes, I have.
Q And what did that counselling involve, what were the issues?
A The issues involved were an evaluation of the stessors that were currently operating in that person's life, the relationship context in which the pregnancy occurred, if it was a minor circumstances in that person's family, the psychological status of that person, her well being, crisis decision making in the past, her methods for utilizing, her methods in resolving those crises. It also included spiritual areas of moral issues that might be relevant to her decision with respect to the outcome of her crisis pregnancy. The meaning of the pregnancy itself for her. We also discussed stages of fetal development, psychological risks to the procedure, et cetera.
Q In that crisis making decision process of counselling, did you discuss information that the woman had at the time of the abortion or lack of it and the effect that had on her in the psychological problems afterwards?
A I'm sorry, could you repeat that?
Q In that -- in doing the counselling in that crisis making decision process, did the counselling include infor -- counselling on the area of whether -- of the information that had been provided to the woman before having an abortion or [154] the lack of information that had been provided to her and any effect that had on her -- on after the abortion, psychologically?
A Yes, I did.
A And you said that you've counselled hundreds of women -- or I'm sorry, maybe 150 women before having an abortion?
A At least.
Q And in that counselling process, does that -- is there

areas of information that -- do you discuss infor -- is part of the counselling request for information that the woman has or believes is beneficial in making the decision?
A I'm sorry, can you...
Q Well, when you counsel the women before an abortion, what are the issues or topics that are discussed?
A We look at what the -- as I mentioned earlier, what the pregnancy means to her. Whether or not any of the risk factors that have been identified in the psychological literature are relevant to her circumstances.

Some risk factors, for example, are the existence of prior children, any coercion, whether or not she has her partner's support. If she's a minor, the issue of her parents. Her information that she has with respect to fetal stages of development, how she became pregnant. Again, her psychological well being, prior decision making in crises, et cetera.

[155] MS. MERSHIMER: Your Honor, in response to Ms. Kolbert's comments, I would say that Dr. Rue is qualified to talk about pieces of information that are required by the Pennsylvania's act and whether it serves a beneficial purpose or whether there could be psychological effects after the abortion by information not being provided.

THE COURT: All right, what -- outline again the area of his expertise in which you wish him to state opinions.

MS. MERSHIMER: The psychological effects following abortions, problem pregnancy decision making with abortions and marital family relationships.

THE COURT: All right, I will grant your motion and let him testify in those areas. And in respect to the objection, it's overruled.

It's a matter of weight, which I will accord to his

testimony determined by his background and his qualifications, his answers and all the factors that go into an evaluation of the weight that should be given to the testimony of an expert witness. I will weigh and evaluate all that in making a judgment as to his testimony. Your motion is granted, shall we -- would you proceed then?

MS. KOLBERT: Yes, your Honor.

MS. MERSHIMER: Yes, your Honor.

[156] *DIRECT EXAMINATION*

BY MS. MERSHIMER:

Q Now we had just started asking some questions. Did you begin to develop a specialty in the area of counselling women for emotional issues following abortion?

A Yes, I did.

Q And can you explain that specialty?

A The specialty was in the area of helping women recover from a painful abortion experience. What I found was women and men described a repeated involuntary grieving that was going on, an inability to put this abortion behind them.

MS. KOLBERT: Objection, your Honor, as to not a proper foundation yet laid about his findings.

THE COURT: Did you wish to lay a further foundation for this?

BY MS. MERSHIMER:

Q You've said that you've had approximately seven -- I'm sorry -- hundreds of cases in your -- in the 15 years of experience, treating -- counselling women in the psychological problems following abortion?

A Yes, and in addition to the treatment of post-abortion pain, I have reviewed some 239 studies in psychological aftermath of abortion, as well as done empirical research on problem pregnancy decision making.

Q And what is involved in clinical treatment of such

women?

[157] A First of all is the assessment of whether or not the aftermath that this woman is experiencing is related to the abortion or if it is related to some traumatic experience that was pre-existing to the abortion.

Any appropriate therapy must commence with the development of a trusting relationship, so the beginning phases of therapy basically entail an opportunity for this person to begin checking out with me, the therapist, whether or not I'm hearing what she is saying or he is saying, whether or not I truly care about that and whether or not I have any experience in an area that this person is experiencing pain in.

It has been my experience with a number of patients that they have sought out help after an abortion to other mental health practitioners and the mental health practitioner says I've never heard of anything called post-abortion trauma and I don't quite understand this. In fact, maybe you should change your values. Given that, these individuals then, in the early stages of therapy, are seeking out an affirmation from me whether or not their pain is legitimate. And indeed, I would say to that person at the beginning stages of therapy, yes, I have seen post-abortion trauma. I have seen this in some women and men and I do not want you to feel isolated.

So the beginning stages of treatment are [158] establishing that important caring relationship. Beyond that, treatment entails the opportunity to fully experience the grief that is involved with the loss that an abortion presents.

These women define their abortion experience this way: They say that I did not, at the time, fully know or understand what my pregnancy meant and what the abortion would do to the pregnancy. Upon reviewing information, seeing things in the media like Life

magazine this month, these individuals may begin feeling the grief that is related to the loss that this abortion caused. As that occurs, the stages of grief must be talked about, must be felt and must be resolved. That's really the second phase of treatment.

And the third phase is stabilizing any of the dimensions of post-traumatic stress that we see here in the example from Dr. Walker. Because as I have written and as I have see clinically, post-abortion trauma, as this is a trauma, follows very closely the diagnostic criteria post-traumatic stress. And these individuals need help in realizing that when they re-experience the painful aftermath of abortion that they're not alone. That this is a normal response to an abnormal situation and that this can be resolved over time.

Post-abortion trauma does not resolve itself typically spontaneously or naturally. Grief usually is best [159] resolved with a caring other and post-traumatic stress, to the extent it is related to the abortion, requires therapy, requires times and requires therapeutic work on the part of the patient to resolve.

Q And this therapy include multiple counselling sessions with women?

A Indeed it does.

Q In the past five years, how many patients would you say that you counselled in general a week?

A My caseload generally ran between 30 and 35 patients a week, and that's over the last 15 years. And approximately 40, sometimes 50 percent of that caseload were in the area of post-abortion problems.

Q Now do you have any experience in the area of problem pregnancy decision making?

A I do.

Q And could you explain that experience?

A In 1973 I was associate director of a problem pregnancy research project in North Carolina where we

looked at the decision making process that women went through in the consortium of agencies as far as making a decision about a pregnancy outcome. And that report was a technical report and written up as to problem pregnancy decision making.

Q. Do you have continued experience in counselling women in that area?

[160] A Pardon me?

Q And did you have continued experience in counselling women in that area?

A Yes, after that time, I commenced my practice in Los Angels and during that time, I have worked with hundreds of not only young women, but also older women who found themselves in a crisis pregnancy circumstance. And they sought out my therapy and my assistance in resolving that.

Q Do you have any experience in the area of marital family relationships?

A Yes, I do.

Q Could you explain that?

A I have worked with couples and families over the years, both spouses together and spouses individually. I have worked with married couples with respect to crisis pregnancies. I've worked with couples who found themselves involved in either psychological abuse or sexual abuse, child abuse, battering, parent/child conflicts, sexual dysfunction, communication disorders, various things like that.

Q Now have you read Sections 3205, 3208 and 3209 of Pennsylvania's Abortion Control Act?

A Yes, I have.

Q And could you turn to Defendant's Exhibit -- it's the last book, it's the manilla tabs -- it's volume two and it's the last section, marked "The Act", page seven.

[161] A What was the exhibit number, counsel?

Q There's -- it's after Exhibit 62.

A After 62. Okay.
Q Page seven, Section 3205. Now focusing on the informed consent provisions under Section 3205 A1 ii, it requires a physician to advise the women of the probable gestational age of the fetus. And Section 3205 A2 i requires a woman to be advised that the Department of Health prints materials that describe the unborn child and that she can review those materials if she chooses to.

Have you read those provisions and reviewed them?
A Yes, I have.
Q And then under Section 3208 A2 on page 19 of the act, that requires the Department of Health to have material available that describes the probably anatomical and physiological characteristics of the unborn child at two week increments, including pictures of the fetus at two week increments. Have you reviewed this provision before today?
A Yes, I have.
Q Now in your experience counselling women, do you have an opinion whether information on fetal development would be information that some women would consider relevant in choosing whether or not to have an abortion?
A Yes, I do.
Q What is that opinion?
[162] A My opinion is that the vast majority of the patients that I have worked with that have obtained abortions that have had negative reactions have said to me that they either knew nothing about the fetal development at the time of the preg -- of the abortion or if they did ask, they were misled in the abortion counselling. That this is nothing but a clump of tissue. It has no characteristics that could identify it as human.

And to the extent these individuals were misled or had insufficient information, I believe that informed consent was not possible and I believe that the

psychological traumatization was worsened because they were misled into believing that this was not a human fetus.

And so I think it's terribly important that this information be voluntarily provided and that an individual avail herself of information so that she can make a knowing, a voluntary and intelligent decision that could effect her for the rest of her life.
Q In your clinical practice, have women sought therapy or counselling before an abortion decision with you?
A Yes, they have.
Q And in your clinical practice, did you offer women information about fetal development even if they did not ask for it?
A I introduced the topic and strongly encouraged them to [163] educate themselves in this area if they have not done so before hand.
Q Now did you insist that they look at materials or just make it available to them?
A I strongly encouraged them. I did not insist on it.
Q Now why was that?
A Well, I don't insist on many things as a psychotherapist and in this area, if a person believes that she doesn't want to look at pictures, doesn't want to have any information, I don't feel it's my role to force that upon her.

On the other hand, it's certainly, I believe, well within my role as a counsellor to say to her, I have worked with a number of people who have been traumatized because they haven't availed themselves of sufficient information to make a knowledgeable decision with respect to an abortion.
Q Is information regarding fetal development something that should be disclosed to a woman -- or saying that the information is available to be reviewed, is that something that should be done or given to a woman

only if she asks for it?
A I think that it's perfectly appropriate for her to receive the information if she asks for it and that she not be coerced into obtaining information.
Q From your clinical experience, do you have an opinion whether merely advising a woman that materials regarding just [164] fetal development are available and that she can decided whether or not to review them is unnecessarily traumatizing to the woman?
A I do have an opinion.
Q And what is that opinion?
A My opinion that offering her the opportunity to be educated with respect to biological and scientific facts, this opportunity which is voluntary is certainly not going to provide the basis of any psychological trauma for a person considering an abortion.
Q Now what --
A If anything, I would say, if I could add, this will help her utilize her own personal values and that those values be informed and based upon some facts.

If, after reviewing these materials, she were to believe that this is, indeed, a human fetus, then she may act and decide accordingly. If, on the other hand, after reviewing these materials she makes the decision that this is not a human fetus and proceeds, I think she is preventing probable increased psychological damage from being misled or receiving fetal -- information about fetal stages of development after the abortion at some later date or in the context of medical care in a wanted pregnancy later on.
Q Now what other information, when you counsel women before is they have an abortion, what other information do you discuss [165] with the woman?
A Well, I think I've answered that question, but we look at all options. We look at the meaning of that pregnancy for her. We look at what stressors are in her

life. Her age certainly has a great deal to do with this. If she is a minor, her decision making may well be framed in fear, misinformation or impulsiveness. Very often a crisis pregnancy unfolds very quickly. By definition, it is a circumstance that demands an attention -- an immediate attention with respect to thinking and ultimately coming to a decision.

The last thing I want her to feel is that she is pressured by anyone into making a decision that is premature to a full understanding of the facts of her circumstance and the facts surrounding any option that she may elect.
Q Now Section 3205 of the act also requires that a woman be advised that the Department of Health publishes materials that list agencies that offer alternatives to abortion, that medical assistance benefits may be available for female care, child birth and neonatal care and that the father of an unborn child is liable to assist and support of her child or that information does not need to be provided in cases of rape. And if the woman chooses to receive these materials, she must be provided them.

Are you familiar with these requirements?
[166] A Yes, I am.
Q And in your experience counselling women, is this information that some women would want to know prior to deciding whether or not to have an abortion?
A Yes, it is.
Q Why is that?
A I think this is information that many people don't know, that they have the right to know. Research by Mary Cunningham Agee indicated -- she asked the question of women that had obtained abortions, if you had known that there were other options for you, would you have elected an abortion? And 90 percent said they would not have.

Many young people have no understanding that the alleged father could be held liable and responsible for financial payments. The whole area of options counselling is terribly important, where the individual recognizes that there are support services across a broad spectrum that are available for her. Very often, in the bureaucratic maze of life, people don't know what support services are available. And indeed, I believe they have the right to know.

Q Now from your clinical experience, do you have an opinion on whether making this information available to the woman could be traumatic or burdensome?

A I do.

Q And what is that opinion?

[167] A I cannot foresee any circumstance where an individual that is offered this information on a voluntary basis could be psychologically traumatized.

Q Now the Commonwealth requires the information we just discussed, in addition to the nature and risk of the abortion method and the medical risks associated with carrying a child to term to be given to a woman 24 hours before an abortion is performed. Are you familiar with that requirement?

A Yes, I am.

Q Do you have an opinion on whether the 24 hour waiting period is beneficial?

A I do.

Q And what is it?

A I think time offers an opportunity to digest information. It is one thing to obtain information. It is another to personalize it. A 24 hour deliberation period is the very minimum I would encourage a person to evaluate the many complex factors involved in this important decision that will, in one way or another, be with her for the rest of her life.

Crisis pregnancy decision making, as I said earlier,

unfolds rapidly. There is also the stigma of shame attached to this. I am a failure because I am victimized, if you will, by my unwanted pregnancy. Very often there is shock involved. There may be no prior experience with this level [168] of crisis decision making. Hormonal changes are operative once a woman is pregnant. This only can compound and conflict the decision making process. All of these factors mix together and create an environment where deliberation can be extremely beneficial.

And lastly, I would add, the opportunity to reflect and draw upon the support of those that love that person, that perhaps know that person better than any social worker of counsellor or psychologist, that's exceedingly important. The 24 hour deliberation period I think is a strong encouragement on the part of the state to do that. And I think it's essential for people when the decision making stakes are high.

Q Now if a woman knows she's pregnant for a week or two, she's had a pregnancy test, she knows she's pregnant, she believes she wants an abortion and she goes to an abortion clinic for that procedure, is the 24 hour waiting provision still beneficial, in your opinion?

A Yes, I believe it is.

Q Why is that?

A We don't know what information this individual has based her decision on. And if it is a fully informed decision, it will simply be a confirmation to her that her decision is right for her. By insuring that she have, on an voluntary basis, information of a biological, scientific nature, I [169] believe it's a way of assisting her in having adequate information to make a decision and for her to check out and affirm the rightness or the wrongness of a decision that she may have made earlier.

I would also add that it has been my experience clinically that women in the crisis pregnancy decision

making may well -- their decision may well fluctuate. That having started, at this point -- this is often true with respect to adoption, I can't possibly give this child away in an adoption and then over a period of time, that decision changes. There is a consideration of an abortion. That changes. I think it's well documented in the literature that across time unwantedness varies as a function of the length of the pregnancy.

Q Of your clinical experience and the review of literature, does time play a role in the crisis pregnancy decision making?

A Time plays an important role in the crisis pregnancy decision making. Very often, a decision is made impulsively to be rid of this crisis and a person may even simply rely on a previous crisis pregnancy experience. We know today in the United States that probably 40 percent of all abortions are repeat abortions. This puts women at risk, having had an abortion, to have a subsequent abortion. Repeated multiple abortions carry certain health risks, both medical as well as [170] psychological.

The time period to evaluate is this really in my best interests, what is involved here, are there other support services available for me, all of that is terribly important in a woman making a decision that is truly informed and beneficial for her.

Q The example I gave you or asked you about if a woman has already known she is pregnant and she goes to the abortion clinic and I asked you about the 24 hour waiting period still being beneficial, is it possible that she will obtain new information or additional information that the clinic that she didn't have before that would aid her in considering?

A Yes, it is. That's what I meant by the state would be insuring a certain standard of information -- scientific information on a voluntary basis that would be very

helpful to her. We simply don't know what information she has utilized in making that decision.

Q Now could you turn to page 20 of the act, Section 3209? That's a spousal notice provision.

A Yes.

Q And that requires that a woman give notice to her spouse, but not consent, just notice, that she's about to have an abortion, except in four circumstances.

A Mm-hmm.

Q Have you reviewed that section previously?

[171] A Yes, I have.

Q And could you look at Defendant's Exhibit 48?

A Yes.

Q Now there will be testimony that Defendant's Exhibit 48 is the proposed certification regarding spousal notice that the Department of Health will use if the spousal notice provision goes in effect. Have you reviewed that before?

A Yes, I have.

Q In your experience counselling married women and men, do you have an opinion on whether spousal notification is generally beneficial?

A I do.

Q And what is that opinion?

A My opinion is that spousal notification is beneficial. People are not perfect, neither are marriages. Most are neither so good that spousal notification is unnecessary or so bad that it would be presumed harmful to the wife to notify the husband with respect to the abortion.

In relationships in particular, people often misjudge their spousal partner. For the majority of couples, communication in very important in marriage. In fact, I believe it's the bedrock of healthy communication -- of healthy marriages. It is advantageous for wives to draw upon the support of their husbands in this crisis decision making period. I believe it's beneficial. The literature is

clear [172] that if there is a conflictual relationship, this woman is at risk for psychologically later on experiencing a painful aftermath from an abortion.

So clinically, I have seen this to be terribly important. That even if the husband were to disagree with her about obtaining an abortion, that this is not bad, that this is not horrible. This is positive in that it provides an open review of a decision with respect to a member of a family -- potential member of the family. And it's extremely important for her to be able to bounce her ideas off of his thinking and vice versa.

And in my opinion, it would be as equally unjust for the wife to exclude him from any consideration as it would be for him to exclude her from any consideration.

Q In your clinical experience, have you counselled battered women?

A Yes, I have.

Q And you reviewed literature in this area?

A I've reviewed some of the literature, yes.

Q Were you here when Dr. Walker testified this morning?

A Yes, I was.

Q Do you agree with her opinion --

MS. KOLBERT: Objection, your Honor. I don't believe that the witness has been certified as an expert of battery.

THE COURT: I will receive the testimony and weight [173] and evaluate it. Lets continue. Overruled.

BY MS. MERSHIMER:

Q Were you here when Dr. Walker -- I don't know if you answered that question. Were you here when Dr. Walker testified this morning?

A Yes.

Q And do you agree with her that battered women tend to deny that they are battered?

A Yes, I would agree with Dr. Walker's perception of

that.

Q Do you agree that battered women are not likely to avail themselves of the exception in Section 3209, that they do not have to notify their spouse?

A No, I would not agree.

Q Why is that?

A I believe that battered wives exist within a context of denial, but that they are not happy deniers. That they are not pleased, that they are not satisfied in their life circumstances. I believe that they want help. That they would seek that help out if help were there and if they felt safe enough in obtaining that help.

Research by Richard Gelles and others indicate that 75 percent seek out help of battered wives. I believe even Dr. Walker, in some of her written materials, has indicated that most battered wives will report, for health problems will deal with health issues. And I think that this is [174] terribly important.

In fact, I see this step where she indicates that she is at risk of being battered, I see this as the commencement, an opportunity for her to commence a path of recovery where she no longer needs exist in denial. She doesn't -- she's not being coerced into therapy somewhere, she's not being coerced into an abortion or not obtaining an abortion. But she is being confronted with an open and honest expression that her circumstances are indeed distressful and sad, that she is battered and at risk of future battering.

And I think these women, with their circumstances, demand a great deal of compassion on our part.

And it is my a hope that this would commence a path of recovery for a person by acknowledging that she is at risk.

Q From your clinical experience, do you believe that counselling is necessary for battered women to recover?

A I believe that battered wives, similar to wives of

alcoholics, similar to wives in dysfunctional marriages, that these individuals are at great risk for reinventing the relationship wheel if they don't receive proper therapy and counselling to understand what psychological factors are involved, first of all, in her getting herself into that circumstance, secondly staying and third, reconnecting with a person very similar, say, to her first husband who battered her. We see this constantly clinically.

[175] A person is married to an alcoholic and comes right back after a divorce and finds an alcoholic who now batters her. So she's a great risk without counselling for reinventing a relationship that's dysfunctional and that could be very painful for her.

Q From your experience and review of literature, do you agree that the majority of battered women will recover from the battered women's syndrome spontaneously when removed from the threatening environment?

A No, I would strongly disagree with that and add that if they are experiencing post-traumatic stress or whatever the particular psychological manifestation of their symptoms is, that these people need professional help to resolve their crisis, to resolve their psychological impairment and to better a future where they are not at risk for further battering or further dysfunctional lifestyle.

* * *

[176] Q Dr. Rue, you testified that in your experience women who had not been sufficiently informed prior to obtaining their abortion, that they had -- that that had some sort of impact on their lives; is that correct?

A That's correct.

Q Could you explain that impact in more detail?

A Well, it could be characterized as intense grieving, distancing in relationships, a mourning, a deep loss, a feeling of tremendous anger and resentment that she was misled. I think generally when a woman feels she has not provided informed consent and information has been insufficient, I think there is generally a sense of regret about what has occurred.

With respect to an individual who is married and she has not notified her husband, had a secret abortion, did not understand what the abortion really did to her pregnancy, this can be a tremendously painful remembering for her and can constitute the basis for a diagnosis of post-traumatic stress which the husband cannot understand. He sees his wife distancing. He sees her emotionally numb and he asks what's wrong. And she says nothing. He says, well, you seem to be different.

[177] And of course, she is different, but she hasn't made the connection herself between the manifestation of these symptoms being tied to her abortion experience. And because all of this interconnects and interweaves, her opportunity to make a decision that is supported pre-abortion, that should necessarily be support post-abortion has been truncated, not only by a lack of information, but also because she doesn't have a support system. S o I see that these individuals can suffer tremendously in a psychological way if they have not received sufficient informed consent.

Q And do you know how long this suffering or the psychological problems can last?

A Well, Speckhard's study found eight to 10 years after an abortion these individuals began ab-reacting, that is, having negative experiences.

The one thing that is characteristic about post-traumatic stress is that an acute reaction is not typical. It's rather that individual chronically attempts to

cope with something that is outside the range of normal human experience. The attempt to process in some way, which is what the re-experiencing phase is, part two here. But more characteristic is the delayed aspect of post-traumatic stress.

Here, an individual will say I feel relief after an [178] abortion, but it is only months and/or years later where she will begin feeling the painful aftermath in a way that can be quite impairing of her relationship, of her career, of her child bearing and child rearing. This delayed aspect is particularly critical.

And I might add that in Science magazine of 1990, Dr. Adler and others reviewed some of the literature on abortions aftermath and Dr. Walker referred to this today. They by no means did a conclusive analysis, a systematic or meta analysis of the literature. And certainly not one that we provided to Surgeon General Koop.

But I might add that Dr. Adler and her colleagues state very clearly in that Science magazine article that the long term effects of abortion are unknown. And you see, that presents a public health risk in terms of a person experiencing this syndrome or depressive disorders or anxiety disorders. It presents a health risk and it's something we should certainly be aware of.

* * *

BY MS. KOLBERT:

* * *

[180] Q Let me ask you this, Dr. Rue. Is it fair to say that in your view, life begins at conception?
A That's a fair characterization of my professional opinion, yes.
Q Is it your professional view that abortion is the

unnecessary taking of human life and is morally wrong?
A No.
Q Is it fair to say that you have a strong personal belief that abortion is the unnecessary taking of human life and is morally wrong?
A I have strong beliefs, but I don't --
Q Is that one of them?
A I don't --

MS. MERSHIMER: Your Honor, I object. I don't see what the relevancy of anybody's personal views are, including counsel or the witness.

MS. KOLBERT: Well, your Honor --

MS. MERSHIMER: It's the testimony as a professional.

MS. KOLBERT: Your Honor, I think it is very [181] relevant in this particular instance, because I think it shows not only the bias of the witness, but how he uses that belief in his particular practice.

THE COURT: Yes, objection overruled, it does go to bias.

* * *

Q Dr. Rue, is it fair to say that you have a strong personal belief that abortion is the unnecessary taking of human life and is morally wrong?
A I believe it is -- abortion is a failure. I believe it is a simple solution to a complex problem. I think it's a poor solution to this complex problem and I am personally not in favor of abortion.

I will add to that that in forming that opinion, I have reviewed the literature from those that espouse a belief in the benefits of abortion, as well as those that espouse beliefs in the harm of abortion.
Q But it's your personal belief, that's all I'm asking. All right --

A My personal belief.
Q Is it also your view that you personally oppose the use of IUD's or other kinds of birth control methods to operate after the -- an egg is fertilized?
[182] A To the extent that an IUD is an abortive fashioned, if we're talking about my personal opinion, yes, I would not be in favor of the utilization of an abortive fashion.
Q So I would also take it to believe that although you're personnally opposed to abortion, that you would favor legal abortion as a public policy matter or not?
A As I said earlier, and I would really reiterate the testimony of Dr. Jacquelyn Forrest, who's director of research at Alan Guttmacher, abortion represents a failure, both on the part of the individual and society.

* * *

Q Let me just see if I understand. As a matter of social policy, you oppose abortion?
A As a matter of social policy, professionally, I think abortion is a poor solution to the complex issues surrounding an unwanted pregnancy.
Q Now Dr. Rue, I'd like to read a quote from you from one of your writings and see if you would continue to agree with this statement. I'm reading a quote from the chapter five that was entitled, "The Familial Context of Induced Abortion" and it was in a book that was edited by James Bopp and which you wrote that article. And let me just read it to you and see if you agree at this moment with this statement:

"That abortion shreds the soul of humanity and the [183] fabric of relationships. It exists for women and yet it is against women, men and children. Like an anesthesia, abortion comfortably numbs all from experiencing the burden of pregnancy. Abortion has

become a social eraser, individually, quickly and secretly eliminating all traces of a problem that is pregnancy, and yet traces always remain within the depths of human kind, the indelible marks of violation appear." Do you agree with that statement?
A Yes, I do.
Q Is it your view that family problems can never be -- or it is your view, is it not, that family problems can never be a justification nor a basis for abortion?
A I don't think abortion ever resolves a family problem.
Q So in your view a woman is never justified in having an abortion because of a family problem?
A Well, I don't know what justified means. Women make the decision to have an abortion basically for what are known as elective social reasons. Wrong sex, wrong timing, career decisions, et cetera.
Q Now wait, that's not responsive to my question, sir. I asked you whether or not it was your view that a family problem can be a justification or a basis that a woman gives for having an abortion?
A It can be a justification.
[184] Q Do you agree with that justification, do you think it's permissible in your value structure for a woman to use that justification for having an abortion?
A Any professional opinion, an abortion will do nothing to solve a family problem.
Q Is it fair to say that you never believe that mental, psychological or emotional problems of any kind would be a justification for having an abortion?
A My opinion is basically based upon the review of Dr. Philip Ney and he has reviewed all mental health indications for an abortion and my --
Q No, I'm asking you --
A My decision is --
Q -- for your opinion.

A My opinion is that an abortion does not ever solve mental or emotional problems and in fact, the research is very clear, that it worsens it.
Q Would it also be fair to say that in your view, incest would never be a justification or a basis for abortion?
A Again, women elect abortion for a varied number of reasons, one of which may be incest, rape, domestic violence, et cetera. I do not believe that an abortion resolves the familial context or nature of the problem.
Q What about rape?
A Nor do I believe abortion resolves the trauma of rape. [185] In fact --
Q Okay, I'm not asking you whether it resolves the trauma. I'm asking you whether that's a permissible -- in your value, permissible justification for abortion?
A I don't think that capital punishment for a human fetus is warranted because of the irresponsible actions of the male.

THE COURT: May I say to the witness you are required to be responsive under our procedures. In other words, you should focus on the question and answer the question and not state some gratuitous information that is not responsive to the question.

I detect you have not been responsive in the last few answers. Would you ask another question. You are required to be responsive.

THE WITNESS: Yes, your Honor.

THE COURT: And I so inform you. Would you -- shall we continue?

MS. KOLBERT: Yes.

BY MS. KOLBERT:

Q Dr. Rue, it is true, is it not, that of pregnancy that is a result of -- in a situation where there's a pregnancy that's a result of marital rape, it would be your view that the marital rape is not a justification or a basis for an abortion?

[186] A It is -- it is my view that marital rape can be a justification, but that it is not in the best interests of the woman to obtain an abortion based upon a marital rape.
Q Now is it -- it's true, is it not, that you've never conducted any independent research on women seeking abortion -- scientific research?
A That's incorrect.
Q You've never -- have you -- it's true, is it not, you've never conducted any independent scientific studies on women seeking abortion? I'm not talking about a review of the literature, I'm talking about conducting studies.
A That's incorrect.
Q Okay and what are those studies?
A I referred to that earlier, in 1973, I was the associate project director of problem pregnancy decision making in North Carolina.
Q Other than that 1973 study, since that time period, have you ever conducted any scientific research?
A I assisted in the project for Dr. Koop --
Q No, I'm talking about not a review of the literature. I'm talking about independent, scientific research.
A Well, I'm trying to answer that, counsel.
Q Okay.
A A meta analysis and a systematic analysis of some 239 studies would be considered original research. And I have [187] conducted that in conjunction with Dr. Tim Rogers, Dr. Wanda Franz and Dr. Anne Speckhard in 1987 for the Office of the Surgeon General in his report to the President.
Q So this meta analysis is the only independent research that you've conducted; is that correct?
A That's correct.
Q It is correct, is it not, that other than the meta analysis of other people's studies, you've never conducted a scientific study about women seeking abortions?
A Well, that's not precisely correct.

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Q All right, I want to differentiate between the situation where you're reviewing and doing a meta analysis or a statistical analysis of other people's work from conducting your own research. It's true that you are not a clinical researcher; is that correct?
A That's correct. I'm -- I have been in the process of writing a text on post-abortion syndrome for the last seven years. I have been amassing clinical data and as you know, counsel, in the area of mental health formulation of diagnoses or mental disorders, there is a phase called the discovery phase. Sigmund Freud commenced a whole field of analytical literature --
Q Let me ask you to be responsive. I don't want to get into Sigmund Freud here. Let me ask you this. If -- other than amassing information from your own clinical practice, [188] have you ever conducted any surveys on a random basis of any women seeking abortion?
A No, I have not.
Q And how about conducting any surveys on a variable basis where you're bringing people together who have perhaps experienced a problem, other than from your clinical practice, and done tests -- psychological tests on those particular individuals?
A Yes, we're in the process of doing that at this very moment.
Q But you have not --
A I have not published on that.
Q Okay --
A Yet.
Q And it's also correct, is it not, that the testimony today, your expert opinion today is based solely on your experience within your clinic practice?
A No, that's not correct.
Q Well, would it be correct to say that it's based within

your experience from the patients you've seen within your clinical practice and the meta analysis that you did for Dr. Koop?
A No, that would not be correct.
Q Would it be correct to say that it is based on your clinical practice primarily?
[189] A No, that would not be correct.
Q Would it be correct to say that it is primarily based from the study of Dr. Koop?
A No, that would not be correct.
Q Okay, what is it primarily based on?
A It's primarily based upon three areas, basically my clinical practice, my research experience and my review of the literature.

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[191] Q Okay, now I also wanted -- didn't you also tell me that you were conducting a scientific research study with a random sample of people for your book?
A No, I did not say I am conducting a random sample. You asked me whether or not we were amassing information with respect to individuals other than my clinical practice and the answer is yes.
Q I'm just having a little hard time understanding it. My understanding of your testimony was that you had three bases. The first base was your clinical study. The second base was the 1973 research --
A Right.
Q -- as well as research for your book --
A Well --
Q -- that you are currently collecting?
A No, my testimony today has been based upon the following: [192] One, my clinical experience. Two, my review of the literature.
Q Okay.

A And three, my research experience.
Q Now I'm trying to understand the research experience.
A All right.
Q The first part of the research experience, the 1973 study I fully understand.
A All right.
Q The second study, what is that?

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Q That's fine. Dr. Rue, it's correct, is it not, that you were the director at Sir Thomas Moore Clinic in California?
[193] A I have been the executive director since 1978 of the Sir Thomas Moore Clinics in Southern California.
Q There are two offices to that clinic; is that correct?
A Yes.
Q Would it be safe to say that the Sir Thomas Moore Clinic has a reputation in the community for helping families and couples to stay together?
A I think it would be safe to say that the clinic has a reputation for providing counselling for couples and families who are in distress, with the hope of reconciling those problems and keeping those families together.

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[197] Q Now, you also testified that you saw a number of different kinds of patients. You saw patients in couples therapy and you saw patients in family therapy and you saw patients individually; is that correct?
A That's correct.
Q Would the couples that you were seeing -- let me just look at the population of couples -- would it be fair to say that you saw half of your practice were couples or

is it more than that?
A I would say slight under half would be couples.
Q And then the remainder was divided between families and individuals?
A Yes.

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[198] Q Would it be fair to say that the percentage of unmarried [199] is about 25 percent?
A 25 percent of all couples?
Q Yes.
A Okay.
Q Is it correct that the couples are coming to you for counselling because they're having an emotional problem and they want to solve that problem?
A An emotional problem or a problem with their spouse, that he or she is to blame.
Q And in the vast majority of these cases, they come to you because they want to stay together in the relationship?
A Some may, some may not. Some want to come to be vindicated that they are not the problem and that their partner is.
Q But the assumption is that they are coming to work on their relationship, that they would like to stay together, otherwise they wouldn't come to you, they would just separate; in that correct?
A Well, some come and say fix her, she's the problem. But yes, I think generally it's a reasonable assumption that when couples continue in therapy, they are seeking the remediation of their problems.

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[204] Q Now, among the patients that you see as

couples, it would be true that some of the people you see are women who become pregnant during the time of the couple's counselling and that they're not there because of the pregnancy, but because they happen to have other problems; is that correct?
A That would be correct.

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[205] Q No, what percentage come to you because she's pregnant, that is, that the problem that they're seeking help for is her pregnancy?
A I don't know that I could respond to that.
Q It's a small number?
A It's certainly not the majority.
Q Is it less than a quarter?
A I don't know. I don't know that I could characterize precisely for you. It's --
Q Is it less than 10 percent? Is it, you know, I want to know, is it a small amount or is it, you know, more than that?
A It's not the majority and it's certainly greater than two percent.
Q Is it less than 25 percent?
A I don't know. I mean, I haven't really done an assessment for you quantitatively of that. I simply can respond as honestly as I can, I don't know what that figure would be.

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[209] Q What percentage of individuals come to you because of a problem pregnancy, that they say I'm pregnant, I need help with my pregnancy, I'm going to see Dr. Rue.
A It would be a minority of individuals that I see.

Q So that the majority in the individual population would be people who you are seeing on an ongoing basis for other things?
A Correct.

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Q Now it was your testimony, I believe, that you had prepared a white paper for Dr. Koop; is that correct?
A That's correct.
Q And that was called The Psychological Aftermaths of Abortion?
A That is correct.
Q Are you aware that that white paper was submitted to researchers at the Center for Disease Control for peer review?
[210] A I was not aware of that.
Q Are you aware today that that occurred?
A I am.
Q Are you aware or would it be fair to say that the researchers at the Center for Disease Control did not come back with favorable reviews of your study?
A I am aware of that. These were blind reviews.
Q Blind reviews, that's right.
A Yeah.

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Q I'd like you to turn to Exhibit 67 and turn to page 11 of that study.
A Okay.
Q And in the fifth paragraph there's a statement by the Congressional Committee, when reviewing the peer review of your white paper, they said -- or in discussing your white paper, they said "in contrast, the right to life white paper misrepresented the study, quoting statistics

for divorce, separated and widowed women having abortions as if they applied to all women having abortions". And they were referring to the David study, as I recall.

Now, let me ask you this. The David study, which [211] was the study by Dr. Henry David, involving a review of psychological aftermaths of abortion; is that correct?

A No, that's not correct.

Q Well, can you describe for the Court what the David study was?

A It's the David, Rasmussen and Holst study and it's 1981 and it is a study that was done in Denmark, looked at 71,000 women who went to term delivery and 27,000 women who elected abortion.

Q Now in your white paper you had relied very heavily on the David study; is that correct?

A We found it to be methodologically the best study that has been done to date an it exhibited sufficient statistical power to predict that real differences were present between groups.

* * *

Q And you cited that study and relied on that study as the best study within your review of the literature; is that correct?

[212] A.We did.

Q But when your peer reviewers looked at your study, they said but you misrepresented the best study that was conducted; is that correct?

A That's not correct.

Q Well, it's correct that they said that -- that's that what it says in this report here?

A No, that's not correct at all, counsellor. First of all, we're blurring two things here. The white paper was

submitted to a peer review within the Federal Government. And generally when these things are done, as is true in any publication, that is resubmitted back to the original authors for a dialogue for discussion. In this case, the authors of the white paper were never treated with the courtesy of having the opportunity to respond to the complaints, if you will, of the peer reviewers. What you're citing here is material from this Congressional hearing, which is not the same thing.

Q Okay, well let me ask this.

A Yeah.

Q Let me go to the peer review. And would it be correct to say that Dr. Dever, who prepared an analysis for Dr. Koop from the Center for -- he's an associate professor, director of clinical epidemiology from the Department of Community Medicine at Macon, Georgia. And he reviewed your work as a [213] result of a request from Dr. Koop; is that correct?

A Yeah, I later found that out, yes.

Q And it would be correct, would it not, that he has said in his review that "the long term psychosocial consequences of abortion are difficult to study and at the outset a defined outcome -- that is difficult to study and require at the outset a defined outcome that is replicable and capable of study. The conclusions presented in the report on the psychological aftermath of abortion are based on an undefined outcome in a meta analysis with major flaws and a best study with major limitations. They should be viewed with "caution."

Is that correct?

A I recall reading that that was his opinion, yes.

Q And was it also an opinion of some of the other peer reviewers -- and I -- have been summarized in the Congressional report; is that correct?

A Generally, the reviews were skeptical of a meta analytic approach, which we found curious, because a

survey of the current scientific literature found some 458 applications of meta analysis in the psychological health sciences field, just within the last two years.

So why we were taking the brunt of criticism for applying standard statistical analysis techniques, we don't know, but...

Q But the criticism was focused on the fact that the way [214] you did the standard statistical comparisons was that they combined outcomes that were not well defined and probably not comparable. That's what the reviewer said; is that correct?

A Well, for example, that's what the reviewers implied, but that's not accurate.

* * *

[215] Q Okay, what were the findings of Mr. David?

A Dr. David's findings were twofold. One, that women who elected abortion as opposed to carried to term were at greater risk to be admitted to psychiatric hospitalization three months post event.

Two, that those women who were void of relationship support, either husbands not involved, divorced, widowed, separated, lacking a support system, they carried a four times higher rate of being admitted to a psychiatric hospital than women who delivered.

These findings are remarkable. They are suggesting that in the worst case scenario we can see public health [216] differences between women who elect two different outcomes. This is the worst case scenario as opposed to those women who seek out counselling. Those women who walk about wounded, who are depressed, suffering PTSD, et cetera. This outcome measure is one of the most defined that one could have. Admission to a psychiatric hospital

Q But it is true that the results of Dr. David's study

only went that the only significant difference that he found in that study went to the rates of admission among women who were separated, divorced or widowed and that this group of women accounted for only 5.5 percent of the entire population; is that correct?

A Dr. David found statistically significant differences in the second category that I responded to, but his findings were the two, that the rates were higher and he did not find statistical differences approaching a .01 or .05 level. But he did find that the rates were higher at all parodies, at all age levels for women who elect an abortion versus those who deliver.

* * *

[217] Q Well, is it accurate to say that the right to life white paper misrepresented the study, quoting statistics for divorced, separated, widowed women having abortions as if they applied to all women having abortions?

A Well, I don't think we ever intended, implied or otherwise suggested that all women throughout the world are going to be equivalent with Dr. Henry David found. It just so happens he has the largest population --

Q But he --

A -- of any groups that have ever been studied in history, to my knowledge, with respect to abortion.

Q Okay and are you --

A The largest.

Q And you also mentioned in your direct examination the study by Nancy Adler, entitled "The Psychological Responses After Abortion"; is that correct?

A That's correct, published --

Q And you consider this to be a valid and review of the [218] literature in this area?

A No, I do not.

Q But you would agree, would you not, that the review of the literature by these scientists, including Dr. David, disagree with your view that abortion is a post-traumatic stress disorder; is that correct?
A They would not only disagree with that, they would disagree that it causes any psychological lasting negative sequelae.
Q And they would -- it is their view "after a review of the psychological literature, that although there may be sensations of regret, sadness or guilt, the weight of the evidence from scientific studies indicates that legal abortion of an unwanted pregnancy does not pose a psychological hazard for most women"; is that correct?
A Well, they say that, but they also say that the long term health risks of an abortion in the psychological area are unknown. They further say, and we quite agree, that the literature is flawed. It is flawed methodologically. 95 percent of the 239 studies we reviewed had inadequate sample size, suffer from sample attrition, where the sample just drops out in the study.

Even Dr. Koop testified on March 16th himself and he said, if you studied women the way the literature has, you can be very badly misled. And that means anywhere from three [219] hours to three weeks to three months post event.

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, et al.	:	**CIVIL ACTION NO. 88-3228**
v.	:	
ROBERT P. CASEY, N. MARK RICHARDS, et al.	:	**Reading, Pennsylvania August 1, 1990 9:30 o'clock a.m.**

. . . . . .

NON-JURY TRIAL - DAY 3

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BY MS. KOLBERT:
[6] Q . . . Dr. Rue, is it your experience -- let me ask you this-- that a woman who decides not to tell her husband of an abortion decision does so on the basis of her best thinking that telling her husband would be in her best interest or would be harmful to her?
A I believe my testimony characterizes spousal notification as beneficial for the woman, that is the wife.
Q No, let me just ask you this.
A I'm sorry.
Q Is it your experience that a woman who decides not to [7] tell her husband about an abortion decision does so because she believes that telling him would be harmful to her?
A Uhm, in some way it would be detrimental, I believe, would be her understanding.
Q But --
A Yes.
Q And she is trying to protect both herself and her

husband from the resulting trauma, is that correct, when she decides not to tell him?
A Not necessarily. She may be trying to protect herself.
Q Okay. And you would also agree that sometimes in a violent marriage forced notification of an abortion could trigger another violent episode?
A It is possible.
Q Would you also agree that if a -- well, let me see if I can characterize your testimony yesterday -- that a woman who checks off the box that says I'm a battered woman and therefore I'm exempted from the provision of the act commences on the path of recovery. Now, you'd agree, would you not, that there are some women who can't check that box and decide that they will not commence on the path of recovery?
A There are women who would choose not to do that, yes.
Q And you would also agree that sometimes the resulting physical injury that would occur when she notifies her [8] husband could include serious injury or death?
A Well, anything is possible.
Q And that sometimes it's true that husbands could use physical or economic coercion to stop an abortion from taking place?
A They can exert great or grave physical violence against her to stop an abortion or to insist on one.
Q And it's your view that -- let me ask this -- it's the primary benefit of forced husband notice that the wife doesn't have to shoulder the burden alone, that she has the benefit of discussion with her husband about the abortion?
A I wouldn't say that that's all that I said; that's part of what I said.
Q Would you agree -- let's just take the first part of

that-- that the benefit is that she wouldn't have to shoulder the burden alone. Would you also agree that that woman could shoulder the burden, that is share the experience, with someone other than her husband and that would meet that criteria?
A No, I would not.
Q It's only her husband that she can shoulder it with?
A Well, presumably he's the one that she loves and has the most intimate relationship with and relies upon his knowledge, his values, his affections, his understandings in a primary way; that's why we call marriages primary [9] relationships.
Q So it would not be your view that that woman could share it with somebody else and shoulder the burden?
A Well, I'm not saying she couldn't and that it never could be. I'm saying that she is married to him, he is the primary love-giver in her life and it would seem reasonable because her life is dedicated in marriage as an institution to be in communication with him and that that would be to her advantage. She certainly could share with a friend, a counselor, whomever, and have support for her decision.
Q And you would acknowledge, would you not, that discussion with the husband is not necessarily an outcome of the statute, that the statute, even though that's perhaps its purpose, could not guarantee that discussion would occur?
A Yes, I think guarantees in life are very limited.
Q And you would agree, would you not, that in some marriages wives don't communicate with their husbands?
A Well, even when they don't communicate, they're communicating.
Q But there wouldn't be a discussion between them, you'd agree about that?
A Well, in terms of an open discussion based upon honesty, the issues at hand, that does not necessarily

follow, but it is certainly the -- the intent of the statute.
Q But you would agree, would you not, that discussion [10] between marital partners is good for both the husband and the wife?
A Indeed I would.
Q And you would agree that it's unjust for a wife to exclude her husband from an important decision, as well as it's unjust for the husband to exclude his wife?
A I agree.
Q In your practice have you ever had an opportunity to counsel a man who has decided to have prostate surgery or perhaps sterilization?
A Yes, I have.
Q And in any of those counseling experiences has the man refused to tell his wife about the experience?
A Well, I can think of a couple of cases where he, for various reasons, did not want her to know.
Q Okay. Now let's think about those situations. Did you encourage the husband to involve his wife?
A You bet.
Q Did he ultimately do so?
A Yes, he did.
Q Assume that he hadn't, assume that he refused to involve his wife. If he refused to do so, would you have told his wife?
A No, I would not have breached the confidentiality of the patient-doctor relationship.
[11] Q And you would agree that in that instance the State should not force the husband to tell his wife?
A I would not agree. I think that the State should require something on that level.
Q But you wouldn't do it as part of your professional relationship?
A Well, I couldn't do it as a psychotherapist. It's beyond the scope of my practice.
Q And that comes from your ethical obligation to your

client?
A And legal responsibility.
Q And you would agree that all the practitioners in the field would have the same ethical obligation?
A I believe so.
Q Psychiatrists would have the same obligation?
A Yes.
Q Psychologists would have the same obligation?
A Yes.
Q Counselors would have the same obligation?
A Yes.
Q Now, you testified yesterday that you also counsel women having abortions, is that correct?
A I counsel women who are confronted with an unwanted pregnancy which may eventually end in an abortion.
Q And you encourage these women to notify their husbands [12] about the abortion, is that correct?
A I encourage these women to participate in the dialogue with their husband about the options that they are looking at.
Q And if she doesn't -- let me ask you this -- if for some reason she does not care if the husband's notified but doesn't want to do it herself, would you do it for her?
A No, I would not.
Q And you would not do that because of your professional obligations as a therapist, is that correct?
A That is correct.
Q And what if the wife refused to notify her husband without, even though you strongly encouraged her to do so, would you do it?
A Absolutely not.
Q And you wouldn't notify her husband about the abortion because of your professional obligations as her therapist?

A That's correct.
Q But nevertheless you believe that the States ought to force notification, is that correct?
A Well, there are times as a professional that I am forced to violate confidentiality. One of those is a duty to report intentional harm that is reported to me --
Q No, all right, my question --
A -- child abuse, et cetera.

* * *

[16] Q Let me give you an example here. Assume that a woman comes to you before she has an abortion and she gets [17] counseling from you and you have provided her personally with information about fetal development, and you've given her all of the information which you think is likely to reduce her stress on the other end.
A Mm-hmm.
Q You've strongly encouraged her to look at pictures and she's looked at those pictures and she's got information about fetal development that you've given her. Then she goes to the abortion clinic, she decides she's still going to have the abortion, she goes to the abortion clinic and she gets information for informed consent, she requests pictures, she sees them, she sees them all again, she gives her informed consent. You'd agree, would you not, that there is no benefit at that point for her to wait an additional 24 hours?
A No, I would not agree with that.
Q Would you agree that there is no benefit that her choice is more likely to be informed?
A I would not agree with that characterization either.
Q You've given her all the information that you think is satisfactory, the clinic has given it to her again, you would not agree that there's an additional -- you would not agree that there is no benefit at that point for her to

go ahead and have the procedure?
A I would not agree. As I testified yesterday, it's one thing to obtain information and it's quite another to [18] assimilate that, to make the experience real and personal. Some people --
Q Well, assume --
A -- function cognitively.
Q -- let's go this far. Let's go this far, let's say that she has had the information from you, she waits a week before going to the abortion clinic. It's at the abortion clinic she gives the legal informed consent.
A Correct.
Q She's had an opportunity to assimilate the information that you've given her. At that point would you agree that there's no benefit in waiting an additional 24 hours?
A No, I would not.

* * *

BY MS. KOLBERT:
[21] Q Dr. Rue, it's correct, is it not, that you've never counseled any women who have had abortions here in Pennsylvania?
A That's correct.
Q And is it also true that you've -- now, you stated earlier that women may suffer physical harm if they notify their husbands in some instances. Would you also agree that women would suffer economic coercion if they notify their husbands or may suffer some psychological coercion, in some instances?
A I don't understand your characterization of economic harm.
Q For example, if a woman was making, with her husband their standard of living was, say, $200,000 a year and she suffered some -- say he threatened to leave and

remove that source of income from her?
A Because she were to have an abortion?
Q Because she notified him that she was pregnant and [22] intended to have an abortion?
A Mm-hmm.
Q You would agree that that's a possible outcome?
A It's certainly possible.
Q You would also agree, would you not, that psychological harm is a possible outcome?
A Anything is possible.

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REDIRECT EXAMINATION

BY MS. MERSHIMER:
Q Dr. Rue, Ms. Kolbert gave you an example of a situation where a woman came to you for counseling and you provided her information concerning fetal development, perhaps Medical Assistance benefits, whatever like that, and then a woman has a week to think about it, she goes to an abortion clinic, she's provided additional information at the abortion clinic and then she asked you whether you still felt there was a benefit to wait 24 hours and you said yes. Now, you're not a medical physician, are you?
A No, I am not.
Q So you don't provide information to the woman in counseling session regarding the medical risks and nature of the abortion procedure and alternatives, do you?
[23] A No.
Q And that would be the additional information that would be provided at the abortion clinic?
A Well, that could be part of it. The additional part of it could be misinformation erroneously provided by an abortion counselor.

• • •

[24] Q Have you ever had occasion to have additional counseling sessions with patients you counseled prior to having an abortion?
A Yes, that's frequently the case.
Q And why would that be?
A This area is subject to tremendous pressure, tremendous [25] anxiety, tremendous shock. There may be relationship conflict, there may be familial conflict, there may be moral conflict. To expect a woman to resolve these weighty matters in the course of a 50-minute session, one 50-minute session, would be completely irresponsible and impossible, in my opinion.

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THE WITNESS: My name -- excuse me -- my name is Watson A. Bowes, Jr., and that's spelled W-a-t-s-o-n, middle initial A, last name is spelled B-o-w-e-s.

MS. MERSHIMER: Your Honor, Dr. Bowes' curriculum [26] vitae is attached as Plaintiff's Exhibit No. 61. To summarize, Dr. Bowes received his Bachelor of Science from Washington and Lee University in 1955. He received his Medical Degree from the University of Colorado School of Medicine in 1959. He was a resident in general practice at the University of Colorado from 1960 to '61 and was a Fellow in obstetrics and Gynecology, Reproductive Physiology Lab at the University of Colorado from '61 to '62 and then a resident in Obstetrics and gynecology at the University of Colorado from 1960 to '65.

He is presently a Professor in the Department of Obstetrics and Gynecology at the University of North Carolina. From 1965 through 1982 he taught obstetrics and gynecology at the University of Colorado as an

Assistant Professor, then Associate Professor and then as a full Professor.

He is Board Certified by the American Board of Obstetrics and Gynecology since 1967. He is Board Certified with the American Board of Obstetrics and Gynecology Division of Internal Fetal Medicine since 1981.

He is licensed to practice medicine in North Carolina and Colorado. He is a member of various professional societies, he has written extensively in medical journals on the topics of fetal maternal medicine and high risk obstetric issues. He has approximately 80 articles published, a vast [27] majority of which are peer review articles. He has a special interest in high risk obstetrics and has written a number of chapters in medical texts on high risk obstetrics and obstetrical emergencies.

DIRECT EXAMINATION

BY MS. MERSHIMER:

Q Dr. Bowes, what does your present practice at the University of North Carolina entail?

A Excuse me, my current practice entails the care of patients, the education, teaching and education of medical students and residents and postgraduate fellows in obstetrics and gynecology and in research in topics in fetal and maternal medicine and high risk obstetrics.

Q Could you explain your teaching responsibilities?

A My teaching responsibilities involve the teaching in all, in all four years of our medical school, there's approximately 160 students per class. Teaching is more intense in the third year when students are in the clinical years of their education. We also have 20 residents in obstetrics and gynecology which are with us for four years and we are primarily responsible for their education and we also have fellows, post-residency fellows who spend two years with us in education in

maternal and fetal medicine and we're also involved in the education of our graduate -- graduated physicians who are in practice and are continuing educational [28] courses.

Q Could you describe your clinical practice, the number of patients, type of surgery being performed?

A My practice is -- I'm a member of a multi group -- of multi-member practice, all of whom are faculty members at the University of North Carolina in the Department of Obstetrics and Gynecology. And my practice at the present time is confined primarily to obstetrical patients, about half of which are considered to be high risk obstetrical patients.

Q And could you describe the research that you've done, briefly?

A The research I do is both supervisory in the sense of supervising our residents and fellows in their research and in conducting my own research in areas of high risk obstetrics and maternal fetal medicine.

Q Now, how does Board Certification in Maternal Fetal Medicine differ from general Board Certification in Obstetrics and Gynecology?

A The subspecialty of maternal fetal medicine involves more intense training and education and expected experience in such things an fetal therapeutic procedures, fetal diagnostic procedures, genetics and ultrasound examinations, a more extensive experience than would be expected of a practicing obstetrician-gynecologist.

Q And could you describe the practice of maternal fetal [29] medicine?

A Well, the practice of maternal fetal medicine involves providing consultation to obstetricians and gynecologists about high risk pregnancies, it involves the care of patients who've been referred for high risk obstetrical problems, fetal abnormalities and often involving fetal therapeutic procedures.

Q Does your practice involve emergency obstetrical procedures?
A Yes, it does. It involves operative obstetrics, including cesarean deliveries, forcep deliveries, procedures to prevent pre-term birth such as cerclage of the cervix, to be specific about one procedure.

THE AUDIO OPERATOR: Would you spell that for me?

THE WITNESS: That's c-e-r-c-l-a-g-e.

MS. MERSHIMER: Your Honor, I would offer Dr. Bowes as an expert in maternal fetal medicine and high risk obstetrics.

THE COURT: Any questions or objections?

MR. ZEMAITIS: I have a few questions on clarifications, your Honor.

THE COURT: Very well.

VOIR DIRE EXAMINATION

BY MR. ZEMAITIS:
Q Dr. Bowes, do you perform abortions?
[30] A I have, yes.
Q Under what circumstances would you perform an abortion on one of your patients?
A If the -- if the pregnancy involved a complication, an obstetrical or a medical complication that has threatened the life of the mother.
Q When was the last time you performed an abortion
A In that context, approximately a month ago.
Q And the time before that?
A I would be involved in those once or twice a year.
Q Now, would you perform an abortion for a victim of rape who became pregnant and chose to end her pregnancy?
A No.
Q Would you perform an abortion for a victim of incest who became pregnant and chose to terminate her

pregnancy?
A No.
Q Are you licensed to practice medicine in Pennsylvania?
A No.
Q You've never been licensed in Pennsylvania, have you?
A No, I have not.
Q And you've never practiced medicine in Pennsylvania?
A I have not.
Q And you are not certified as a specialist in emergency medicine, are you?
A No, I am not.
[31]Q Now, I notice in your curriculum, Dr. Bowes, that you are a member of the American Association of Pro-Life Obstetricians. Could you tell us what that organization is?
A That organization is a nationwide organization of obstetricians, gynecologists who are, in their general approach to obstetrics and gynecology, defined as interested in the fetus, primarily in the well-being of the fetus and mother as two individuals.
Q Are members of that association, generally speaking, philosophically opposed to abortion, except where necessary to save the life of the mother?
A Yes, there are.
Q How long has that organization existed?
A I can't tell you exactly how long that organization has existed.
Q How long have you been a member of that organization?
A Well, I've been a member of that organization probably for eight years or nine years.

* * *

[32] MR. ZEMAITIS: I have no further questions on qualifications, your Honor. We have no objection to Dr. Bowes testifying as an expert in the subjects mentioned by Ms. Mershimer.

THE COURT: Very well, shall we proceed then?

DIRECT EXAMINATION (Continued)

BY MS. MERSHIMER:

Q Dr. Bowes, are you also a member of ACOG?

A The American College of Obstetricians and Gynecologists, yes, I am.

Q Dr. Bowes, in front of you in a manila tabbed binder is Defendant's Exhibits. On Defendant's Exhibit No. 62 is the tab marked "The Act," do you see that? You can shut that other book, if you want to. Behind Defendant's Exhibit 62 is a document marked "The Act," do you see that?

A Yes.

Q Could you turn to Page 5 of the act? And do you see the definition of "medical emergency"?

A Yes.

Q Have you reviewed that definition before?

A Yes, I have.

Q Now, there has been testimony previously that this definition in vague and confusing. In your practice of [33] maternal fetal medicine and high risk obstetrics, do you agree with that opinion?

A No.

Q Why?

A This seems to me to be a definition of medical emergency that allows, because of its statements about clinical judgment being allowed in which the physician is allowed to assess risk of impairment of bodily functions, to be a definition which would allow practice consistent with the good standards of care.

Q Now, in this case Dr. Bolognese testified that the

term "Serious" in the phrase "Serious risk" is vague and not a medical term; do you agree with that statement?

A No, I don't.

Q Why is that?

A In the practice of medicine we are always called on to judge risk in almost every situation we encounter and it's, it varies from very mild risk to very serious risk, based upon the estimate of the physician about the consequences of the condition, consequences of the treatment. And that's a well known, that's a well known quality of a good physician, to be able to judge those risks and it's not vague. There is also testimony regarding the phrase "substantial and irreversible impairment of a major bodily function." Do you have a problem understanding that phrase?

[34] A No.

Q Within the context of performing abortions?

A No.

Q Why not?

A The risk of substantial and irreversible impairment in any medical or obstetrical condition as it might relate to abortion is the -- what is being judged all the time in the evaluation of a patient with those problems, that is to say, what might happen if these conditions went untreated what bodily organs might be impaired, what functions of those organs might be impaired. That's a very straightforward medical assessment.

Q Do you know what the term "substantial impairment" means?

A Yes, I do. Substantial impairment implies that that impairment will either be to conditions that are irreparable, which organs actually die in which the patient is placed at serious risk of death or where this patient is placed at significant risk of being -- of having some irremedial organ damage.

Q And do you know what the term "irreversible

impairment" means?
A Irreversible means that it is not reversible; that is very straightforward.
Q How about "major bodily function"?
A Well, the major bodily functions are, I think, those [35] which involve the vascular systems of the body, the nutritional systems of the body, the excretory systems of the body, the cardiovascular systems and the central nervous system. All of those are -- function in a way to maintain a person's life and well-being.
Q Do you have an opinion whether the phrase "serious risk" is an important component of the act's definition of "medical emergency"?
A That's a very important component of this definition because it is risk that is always being assessed in a medical context, the risk of a condition progressing to serious injury or to irreparable, a state where it's irreparable.
Q And do you have an opinion on whether the "good safe clinical judgment" phrase is an important component of the act's definition?
A This is also a very important phrase because it allows the physician to use what he or she has been trained to use, which is the collection of data, assessment of data and the extraction from those assessments of the possibility of problems occurring that must be prevented by treatment, et cetera. This is the daily behavior of a physician, that this in what a physician is involved in doing.
Q Do you have any trouble understanding or applying the phrase "good faith clinical judgment" in the act?
A No.
[36] Q Why is that?
A Well, good faith clinical judgment simply means that the physician is using the education that's been provided, the data that is provided and the clinical experience

which has been accumulated and using it to the best of her or his ability to provide care for a patient.
Q In the performance of abortions can you think of any medical situation where a woman would need an immediate abortion that would not fall within the act's definition of medical emergency?
A No.
Q Now, there's testimony by Dr. Davidson regarding inevitable abortions which he characterized as vaginal bleeding, some lower abdominal cramping and the dilation of the cervix. Do you agree that pregnancies such as these ultimately must be terminated?
A Yes.
Q Now, he also said there was a variation of inevitable abortions that depends upon the urgency of the procedure and that the urgency depends upon the extent and amount of bleeding that the patient is suffering. Would you agree with that?
A I would agree with that.
Q Now, he said that such a situation required immediate attention within a few minutes to a few hours; would you [37] agree?
A It would depend upon the extent Of the bleeding and the, especially the extent of the bleeding and hemorrhage, as to how quickly one would have to respond to that situation.
Q Would you be able to wait 24 hours to perform an abortion in the case of inevitable abortion?
A The very fact that it is inevitable means that it is going to occur sometime within the next few hours or possibly even day or two, but in the standard medical practice, when an abortion is recognized as being inevitable, the termination of the pregnancy is recommended. Now, that doesn't mean it has to be done in the next ten minutes, but because it will be inevitable and there are risks to allowing the pregnancy to proceed

to the point where there is major hemorrhage occurring, those pregnancies are usually terminated.

Q Would inevitable abortion fa11 within the act's definition of a medical emergency?

A It certainly would when there is hemorrhage, serious hemorrhage occurring to the patient.

Q And if an abortion was not performed, what would be the outcome?

A Well, in most cases there might be extensive hemorrhage and blood loss and shock, if the -- if the spontaneous abortion at that point proceeded to those stages. If the [38] pregnancy was not terminated and products of conception remained, an infection could occur, the patient could become septic. There are consequences of infection that would have to be taken into consideration.

Q Now, there's testimony regarding preeclampsia in this case. Could you tell the Court what that is?

A Preeclampsia is a condition which occurs in pregnant women and is defined by really three manifestations: high blood pressure, protein being excreted by the kidneys in abnormal amounts and often swelling or edema or fluid retention.

Q And when does preeclampsia normally occur?

A Well, it can occur throughout pregnancy. It is more commonly found in the third trimester or the last third of pregnancy, but it can occur as early as 18, 19 or 20 weeks.

Q And is termination of the pregnancy required in such cases?

A Termination of pregnancy is the treatment, is the ultimate treatment for preeclampsia, yes.

Q And would preeclampsia fall within the act's definition of a medical emergency?

A Yes; it would.

Q Why is that?

A Well, in the cases in which it becomes severe, that is to say that the patient's blood pressure is very high and other [39] complications of the preeclampsia are occurring, such as liver involvement, central nervous system involvement, this would clearly fall within the definitions of emergency, a medical emergency because it has the significant risk of impairing bodily functions in a permanent way or leading to the patient's death. Eclampsia and preeclampsia are still recognized as among the leading causes of maternal mortality.

Q Now, there is prior testimony at a preliminary injunction hearing by Dr. Dratman and she gave the following example and statement, and I quote: "Let's say a 16 year old woman comes into the emergency room, she's pregnant, she is about 18 weeks pregnant, she is swollen, her blood pressure is 210 over 160, normal being between 100 and 120 over 60 to 80 in that age range and her urinalysis shows a considerable amount of protein in the urine and her reflexes are very brisk. This is a clinical syndrome known as preeclampsia or toxemia of pregnancy. This is in obstetrical terms a medical emergency." Do you agree with that statement?

A I would agree with that.

Q And then she went on to say "However, under this statute, before I could operate as if this were a medical emergency, I would have to prove that irreversible major bodily harm would come to this patient if I were not to wait for a judicial bypass to go through." Now, do you agree with that statement?

[40] A I do not agree with that statement.

Q And why is that?

A Well, given the case that's been described, there is serious risk present of major bodily injury, there's even serious risk of death, and that's all that's required to allow this to be interpreted as one of those cases that would clearly be covered by medical emergency and the

pregnancy could be and should be terminated promptly.
Q Do you have an opinion of the consequences of if a physician in such a circumstance would fail to terminate the pregnancy?
A I think that could be considered negligent care.
Q Now, there's also testimony about HELLP Syndrome. Could you describe that?
A HELLP Syndrome is an acronym which describes some of the consequences of very severe preeclampsia. It involves abnormalities in the coagulation system, abnormalities of the liver function primarily and severe anemia because red blood cells are being broken down rapidly. This is a state of very severe preeclampsia.
Q And when does HELLP usually occur?
A Again it can occur throughout pregnancy at any time preeclampsia can occur, being one of the, if you will, serious complications of preeclampsia.
Q Does it usually occur when a person wants the child?
[41] A Well, to the extent that preeclampsia is usually occurring when pregnancies are wanted, if you will, the pregnancies are well into the latter part of pregnancy, most cases of HELLP Syndrome in fact do occur in women who want their pregnancies.
Q And what is the treatment when a woman has HELLP?
A It's delivery of the pregnancy.
Q And how quickly?
A It needs to be terminated within a few hours. By that I don't mean within ten minutes or within an hour, there is certainly time for -- to be sure that the diagnosis is correct, there is certainly time to provide those -- that type of intensive care that would be necessary in a patient such as this and that could be done within a few hours.
Q Does HELLP fall within the act's definition of medical emergency?

A It clearly falls within the definition of emergency.
Q Now, there was also testimony about spontaneous ruptured membranes. Now, if that -- do you know when that typically occurs in a pregnancy?
A Again, a spontaneous rupture of the membranes can occur literally at any time in pregnancy. It is most frequent near term, at the end of pregnancy, but it can occur to a patient any time throughout pregnancy.
Q Now, if a membrane has just broken but there's no fever, [42] what's the course of treatment?
A In -- late in pregnancy, very near term, often the patient would be delivered simply to avoid any complications. Earlier in pregnancy, let me say around 24, 25, 26 weeks gestation, the usual treatment of that is expectant management, meaning that you simply allow the patient to remain generally in the hospital under close observation, to allow the fetus to gain more gestational age and grow.

Now, if it's even prior to the time when the fetus might be viable if delivered, the treatment of premature ruptured membranes is open to a lot of debate and certainly involves a discussion with the patient at that time of the risks of proceeding in an expectant manner, that is to say not delivering the baby, or having the pregnancy terminated at that time and those decisions are based on the patient's evaluation with her physician of the risks involved in each of those courses of action.
Q Is there discussion of the risks with the patient regardless of whatever the gestational age of the fetus is?
A Yes, there is.
Q And would such a situation fall within the act's definition of medical emergency, where there's no fever?
A Well, if we're talking about just ruptured membranes without evidence of other complications such as infection, fever, infection, it would not be an emergency. If on the [43] other hand the patient has developed a

fever and there are other -- and there are signs of infection, the infection in, within the uterus involving the fetus, the fetal membranes, the placenta, that becomes an emergency and would certainly be included within the definition of medical emergency in this act.

Q If there is a fever involved or an infection with a ruptured membrane, how promptly should one perform an abortion or a termination of pregnancy?

A Within several hours this patient should be delivered.

Q Now, do you know what an ectopic pregnancy is?

A Yes.

Q And could you tell the Court what that is?

A An ectopic pregnancy is a pregnancy which has occurred outside in which the embryo is really outside of the uterus, intrauterine cavity. The most common ectopic pregnancies occur in the fallopian tube and are often called tubal pregnancies.

Q Now, when an ectopic pregnancy is discovered, what is the usual course of treatment?

A The usual course of treatment is to terminate the pregnancy.

Q Does that fall within the act's definition of medical emergency?

A Yes, it does.

[44] Q Now, in your experience are physicians called on daily to make decisions where medical conditions are life-threatening with great serious risk to the patient's health?

A Physicians are called on to make those decisions, yes.

Q Now, do you find it burdensome or confusing to apply Pennsylvania's definition of medical emergency in the context of abortions and in your medical practice of obstetrics and gynecology?

A I do not.

Q An why is that?

A It seems to me the definition of medical emergency

allows two very important things for the physician, first of all, to exercise a good faith clinical judgment and to do that in assessing risk of any condition leading to serious injury or to death. And those are complements of a physician's practice in almost any area of emergency medicine.

Q Now, have you reviewed Pennsylvania's act prior to today?

A Yes.

Q Are you aware that there are various sections that require certain procedures to be done unless there's a medical emergency present?

A I am.

Q Now, could you please turn to the act again, Page 6, and focus on Section 3204 regarding medical consultation?

A All right.

[45] Q Now, Section 3204(B) requires that except in a medical emergency, a physician is to refrain from performing an abortion upon a woman until he or she or a referring a physician is consulted with the woman to determine whether the abortion is necessary, based on all factors relevant to her well-being. Is that correct?

A That's correct.

Q Is it standard medical practice for a physician, a referring physician to consult with the patient prior to performance of the surgical procedure upon the patient to determine whether the procedure is desired and necessary?

A Yes.

Q Absent a medical emergency as defined in the act, would you terminate a pregnancy without first consulting with the woman to determine whether she wished to have her pregnancy terminated and whether the termination is medically indicated?

A No.

Q Why is that?
A Because, like any medical procedure, it involves certain risks and the patient should be apprised of those risks and the alternative procedures which can be performed or are available. That's simply part of normal informed consent to which every patient is entitled. Now, would you turn to Page 7 and look at Section 3205 [46] regarding informed consent. Have you reviewed Section 3205 before today?
A Yes, I have.

* * *

Q Now, absent medical emergency as defined in the act, is it standard medical practice to assure that the patient is informed of the risks and alternatives involved in a surgical procedure prior to its performance?
A Yes.
Q Now, does the act require a physician's delay in abortion by 24 hours when a medical emergency exists?
A No, it does not.
Q Can you conceive of an obstetrical situation in which a delay of 24 hours would increase the risk of the patient yet not qualify an a medical emergency within the act's definition?
A I cannot conceive of such a situation.
Q Now, do you have an opinion on whether the act's reliance-- excuse me, strike that.

Would you focus on Section 3206 on Page 10 of the [47] act? And that's a provision concerning parental consent?
A Yes.
Q Have you reviewed that section before today?
A Yes, I have.
Q Now, absent a medical emergency, is it standard medical practice to notify and obtain the consent of a

parent prior to performing a surgical procedure other than an abortion on a minor?
A Yes, it is.
Q Do you know of any conditions that would require an immediate abortion without a parental consent that would not fall within the act's definition of medical emergency?
A No, I do not.
Q Now, please turn to Page 20, focusing on Section 3209, spousal notice? Have you reviewed that section before today?
A Yes, I have.
Q Is the act's definition of medical emergency sufficiently clear and flexible enough, given the reliance upon the physician's good faith judgment, to allow a physician to determine whether or not an abortion must be performed immediately prior to notifying the spouse?
A Yes, it does.
Q Now, why do you say that?
A It seems to me that the physician's judgment about medical emergency involves an assessment of the time that is [48] involved in responding to and correcting the situation and if it's pregnancy termination of abortion that's necessary, and it must be done prior to the notification of the spouse to prevent serious injury to the patient or to prevent death, it's within that patient's -- that physician's good faith judgement to make that assessment and carry out the abortion, it's very straightforward.
Q Now, on Page 22 of the act, there's Section 3210 regarding determination of gestational age. Have you reviewed that section before today?
A Yes, I have.
Q Is it standard medical practice to determine gestationallage prior to performing an abortion?
A Yes, it is.

Q Why is that?
A Well, there are at least two reasons, one is that the type of procedure which is performed in abortions may change with the gestational age of the pregnancy and so it's important to know the gestational age for that reason.

Secondly, particularly in late abortions, it's important to know whether the pregnancy has reached the state where the fetus, if born, would be viable, so that's another important reason for making that determination.
Q In the context of a medical emergency does the physician have the flexibility to determine whether delaying an [49] abortion to determine gestational age will result in the woman's death or will create a serious risk of causing substantial and irreversible impairment of a major bodily function in determining gestational age?
A I'm sorry, I didn't quite understand that question. Could you repeat it?
Q Certainly.

Let me put it this way: Where an abortion must be performed so quickly that a physician does not have adequate time to make a determination of gestational age of the fetus, will the woman's condition fall within the act's definition of medical emergency?
A Yes, it would, although that would be a very rare situation, but it would certainly fall within that definition.
Q And could you give us examples of that?
A Well, it would be possible that a woman would enter an emergency room bleeding from what we previously stated would be an inevitable abortion and it might, under those circumstances, she might not know precisely how far along she was in her pregnancy. But the treatment for that patient who is hemorrhaging is to terminate the pregnancy and it wouldn't matter whether she was four weeks or nine weeks or twelve weeks and it wouldn't necessarily -- and it wouldn't be necessary to

postpone the procedure to terminate the [50] pregnancy to do such things as ultrasound, if it wasn't immediately available, or such, because the determination of gestational age within those ranges in that patient would make no difference about the treatment. So in that situation, clearly, the physician would be advised to proceed directly to terminating the pregnancy.
Q Now, turning to Page 23 of the act regarding Section 3211, that prohibits abortions of fetuses of 24 weeks gestational age or more unless a physician reasonably believes that the abortion is necessary to prevent the death of the woman or substantial or irreversible loss of a major bodily function will occur. Are you familiar with that section?
A I am.
Q Now, in such situations is it standard medical practice to perform the pregnancy termination in a hospital if at all possible?
A Yes.
Q And is it standard medical practice in those situations of abortions, 24 weeks or more gestational age, to have a second physician in attendance to resuscitate the infant?
A It is and if I could just interject here, I think the term "abortion" used for terminating a pregnancy after 24 weeks gestation is -- is problematic because although we're terminating the pregnancy, clearly after 24 weeks gestation [51] there is a high probability, with proper care, that the fetus will survive, once born, and those are then not by definition abortions. They're pregnancy terminations, but not abortions, as I understand it.

But the point about the second physician is that the care of that infant, when it's born, requires a substantial amount of intensive care and would require another physician.
Q Are obstetricians faced with liability concerns these

days?
A Yes.
Q Can you tell us a little bit about that?
A Well, obstetrics and gynecology and obstetrics in particular has been among those specialties where some of the highest instances of litigation and some studies show that 50 to 75 percent of obstetricians will at one time or another be involved in some liability issue.
Q Now, in light of liability concerns, is it common to have a second physician occur in the need for immediate pregnancy termination, is that practical?
A If -- a second consultation is -- is advisable in any situation where there is potential liability risk where another opinion is not only helpful in determining the appropriate medical care, but it's helpful in providing good evidence that the physician was acting in the best, you know, in providing good standard care, if I understand your [52] question.
Q And that would apply with pregnancy terminations of fetuses 24 weeks or more gestational age?
A Especially in those cases because this is an area where there can be a lot of controversy about the -- about the degree of viability, et cetera, et cetera.
Q And is it also common in such situations for the physician to record the basis of his medical judgment to perform the procedure in the patient's medical chart?
A Absolutely, that's simply good medical -- that's simply good documentation of the medical care.
Q Now, in your opinion does the act's definition of medical emergency permit a physician to rely on his or her good faith clinical judgment and provide sufficient flexibility to determine whether there's sufficient time to perform any of the requirements set forth in Section 3211(C)?
A I believe it does that, yes.
Q Now, Dr. Bowes, if a physician could determine that

a pregnancy termination of a 24-week or more gestational age fetus is necessary to prevent the death of a pregnant woman or substantial and irreversible impairment of a major bodily function making its performance permissible under Section 3211(A) and (B), should that physician similarly be able to determine whether medical emergency exists?
A Yes.
[53] Q Why is that?
A Because these conditions, be they a medical complication to pregnancy or an obstetrical complication, fall within that range of expertise of an obstetrician gynecologist to determine whether the patient is at substantial risk of bodily injury. That's what high risk obstetrics in particular deals with all the time and those judgments are made frequently and commonly.
Q Now, there's been testimony in this case that the definition of medical emergency contained in the act is different from other definitions of medical emergency. Do you agree with that?
A Yes, because I suspect that there's many different definitions of medical emergency.
Q Now, in the context of performing abortions, do you find that difference to be burdensome, confusing?
A No, I don't find this definition confusing.
Q Now, why is that?
A It seems to me that the definition is straightforward because it contains two very important elements, and that is that the physician is allowed to use judgment, good faith judgment, and to assess risks, and those are really the essence of a physician practicing, especially in an emergency situation those kinds of decisions have to be made using both the judgment and the assessment of risks, and that, both [54] those things are contained in this definition. That's very important.
Q Does the act's definition of medical emergency

permit a physician to act consistent with good medical practice in your opinion?
A It certainly does.
Q Now, Dr. Bowes, there's been testimony in this case concerning the mortality risks of performing an abortion for each week after eight weeks gestation and the testimony was that mortality increases by 50 percent each week. Do you agree with that testimony?
A I think the data would show that there is a gradual increase of -- of abortion risk -- of mortality risk with abortions at each gestational age, but the way the data is collected, it is collected by groups of weeks of gestation. For example, under seven weeks, eight to ten weeks and so forth, and there is an increase between those blocks of gestational age that would amount to about 50 percent of a very tiny risk of mortality increasing by 50 percent to another very tiny risk of mortality. So that statement with -- I'm not sure it's absolutely true week by week, because I know of no one that's actually done the data that way, but it does increase as gestation increases.
Q But you're saying that it doesn't increase necessarily 50 percent every single week?
[55] A I don't think it increases 50 percent each week, at least I know no data that shows that. I know the data that shows, collected by the CDC, that shows that it increases by blocks of weeks, by periods of gestation, but those are not necessarily individual weeks.

But let me expand on that. Even if I were to find that if that data showed week by week increments, we're talking about very, very small, absolute mortality risks. Even though the risk may increase by 50 percent, it's increasing by a very small absolute number.
Q And do you know what that number is?
A Could I refer to the CDC data?
Q Certainly.
A Okay. This is the report issued in November of 1985

by the Centers for Disease Control and Abortion Surveillance from the U.S. Department of Health and Human Services, and in that data on Page 40 it shows that the risk of mortality per 100,000 procedures performed under eight weeks of gestation is 0.5, 0.5 deaths for 100,000 procedure performed.

Now, the next block of data is the nine to ten-week gestational age range and at that point the risk of maternal mortality is 0.8 per 100,000 abortions performed. To illustrate my point that these are increases but we're talking about absolute numbers of deaths that are very, very small.
[56] Q Could you provide the rest of the risks by gestational weeks in that report?
A All right. At 11 to 12 weeks of gestation, the risk of maternal death per 100,000 procedures is 1.1. At 13 to 15 weeks it's 1.5 and at 16 to 20 weeks, well, you now see a fairly significant jump in the risk, it's 7.8 per 100,000 and that's where we're well into the second trimester of pregnancy.
Q Is that a four-week block of time?
A That's a four-week block of time and then over 21 weeks gestation it's 3.6 deaths per 100,000 procedures.
Q And could you tell us what years of data were used in that study?
A These, the years included in this particular data set was 1977 to 1981, and that's the most recent data.
Q And do you have any data concerning the risk of complications?
A Yes, the risk of complications I have of abortions comes actually again from the CDC and I am reporting from a publication entitled "Abortion Practice" by Dr. Warren Hern, which was published in 1984, and in that on the chapter of -- that regards complications of abortion, he has a table summarizing the data from the Centers for Disease Control from 1975 to 1978. Now,

these are what they call major complications of abortion, these would be major hemorrhage [57] requiring transfusion, perforations of the uterus, other complications requiring hysterectomy, those are -- but these are major complications. It shows actually that the incidence of these major complications goes down between six weeks and the block of time between seven and eight weeks and the block of time between nine and ten weeks. Now, even at that, these complications never increase above 0.5, that's one-half of one percent, until one gets over 13 weeks gestation. They remain in that very low range and in fact are decreasing throughout the first trimester of pregnancy, the incidence.

Q So the overall risk by week that then increases either by morbidity or complications is very low?

A It's very low. It remains very low. In fact, the major jump in complications occurs at 15 weeks gestation where at during the time of those -- this data was collected, the type of abortion had necessarily changed from the curettage-type of abortions to the installation of saline and of prostaglandin, and there the complication rate is listed at 1.4 percent.

Q Are you aware or is it possible to measure the increased risk on -- excuse me -- morbidity or complications for a 24-hour period of time?

A No, it's not because the increase in risk does not occur in that short period of time and the ability to precisely [58] time or date a pregnancy within a 24-hour period is impossible, you can't make that distinction within a 24-hour period.

Q And would you consider abortion a safe procedure?

A As compared to other medical procedures and particularly in the first trimester, it's a very safe procedure.

* * *

Q Dr. Bowes, in your clinical practice at the University of North Carolina do you counsel women regarding the issue of abortion?

A Yes.

Q And how many women a week do you counsel?

A It would vary, but probably average one or two.

Q Okay, and in what context do you counsel women?

A It's in the context usually of pregnancies which are involved in high risk situations, complications of their pregnancies and their either medical or obstetrical [59] complications.

Q And does it ever occur where it's not in the context of high risk?

A Yes, on occasion it does.

Q And when you counsel these women is that in the context of providing women information to obtain so that they can provide their informed consent to have an abortion?

A Yes.

* * *

[60] Q What does informed consent mean or involve in your opinion?

A Informed consent involves providing the patient with the -- with information about the risks of the condition that she happens to have at the time, the risk of the -- any medical or surgical procedures or therapies which are advised and the risks of alternative therapies or alternative procedures.

Q Now, would you turn to Page 7 of the act, in reference to Section 3205(A)?

* * *

Q And I believe you testified that you've reviewed this

section before?
A Yes I have.
Q Now, one provision of Section 3205(A) requires a physician to tell a woman the gestational age, probable gestational age of the fetus and it also provides that the woman be told that the Department of Health has materials describing fetal development and that those materials are [61] available for the woman to see, if she chooses to; is that correct?
A That's correct.
Q Now, in your experience or practice, do you have an opinion whether this requirement is beneficial to the woman?
A I think providing them the option of reviewing this material is beneficial and is part of a reasonable informed consent.
Q Now, why do you believe that?
A The period of gestation, the duration of gestation is important because it may affect how the patient views the, not only the risks which should be provided by the physician, but the development of the fetus. She may not be aware of the nature of fetal development and I think that's part of her having a fully -- being able to make a fully informed decision about pregnancy termination.
Q Now, when you counsel women regarding informed consent, do you offer them the opportunity to see pictures regarding fetal development?
A Yes.
Q And in your experience have women wanted to see those pictures?
A Yes, it often is helpful in really making more clear than just a simple description of fetal development. If I can give you an example, we recently had a young woman with a [62] fairly far advanced tumor, it's called a neuroectodermal tumor, which is a highly malignant

tumor, was referred to us because she became pregnant -- during her course of therapy. And the oncologist, the physicians who were caring for the patient and treating her, recommended that an abortion be done. And in counseling this patient, she in fact wanted to see this material and elected to review it and, after doing so, was inclined and in fact chose to continue her pregnancy, in spite of considerable risks to her. But all of the options were provided to her and she was very grateful for having that opportunity. So there are occasions when it can make a very big difference.
Q Now you said that you offer women the opportunity to see pictures. Do you offer the opportunity to see pictures of fetal development regardless of whether they ask for it or not?
A Yes, I tell them that it's available and we have fetal, actual pictures of fetal development. In many cases we even offer them the option of seeing an ultrasound, if they want to see that.
Q And some women accept the offer and some women don't?
A Yes, that's true.
Q And do you ever force them to look at those materials?
A No.
Q Now, why is that?
[63] A Well, I -- you don't-- it would be unreasonable to force a patient, you can't force a patient to do anything. I think you advise patients, you offer them information, You provide them the opportunity, but you don't force the patient to review this material, nor would I under other circumstances providing informed consent for other -- other procedures.
Q Do you try to force a woman to make a choice whether to have an abortion or not, either way?
A No.

Q And why is that?
A Well, it's the patient's prerogative and option to make a decision about abortion pregnancy termination, but I believe she needs to make that decision after being fully informed about the alternatives, about the risks and about what is involved in the procedure.

Now, there's a provision in the act that requires a woman to be advised of the risks of treatment of the nature of the procedure and alternatives. Do you do that in an informed consent procedure?
A I do.
Q And do you consider that a standard part of informed consent?
A I think that's a standard part of informed consent in this situation and in all others.
Q Now, another section of the act requires to advise the [64] woman of the risk of carrying the child to term. Do you do that in your practice of an informed consent?
A I do.
Q Now, why is that?
A Well, one of the alternatives to pregnancy termination having an abortion and the obvious alternative is to not have abortion, which involves the patient continuing the pregnancy on throughout the natural period of gestation. And a woman needs to be advised of the risks of doing so before she can make an informed decision about whether the pregnancy should be terminated.
Q Now, there's been testimony that advising a woman of the risks of treatment or the risks of carrying the child to term or the availability of fetal development information could increase a woman's anguish in the decisionmaking process; do you agree with that?
A No. A qualified no. It might increase in some cases, but I think it's been fairly well established that the decision about abortion itself is a anxiety-provoking

situation. The woman is already in a period of considerable concern and anxiety and anguish over the decision about terminating pregnancy and I know of no way of quantitating whether the -- that additional information increases anxiety, but it's certainly necessary for her to make an informed choice.
[65] Q Now, an argument has been made that when they're advised of this information and it increases their anxiety, that that will also increase their risk of complications, the performance of abortion. Do you agree with that?
A Well, I know of no evidence to prove that statement. I just -- no.
Q Now, the act requires that a woman be advised that material exists, that she may be entitled to Medical Assistance benefits, that there are optional organizations that offer alternatives to abortion and that the father may be liable for support payments and that if the woman wants to review those materials, she may, but she does not have to.

Do you believe information that I just described like that should be part of informed consent procedure?
A I think it's part of the information a woman is entitled to.
Q Why is that?
A Well, it simply is involved in the assessment and in the -- of the alternatives to abortion, which is carrying the pregnancy on, which would require her to evaluate her means, her -- her resources or financial and other support.
Q Do you believe it is traumatic to tell a woman that such materials exist and give her the option of choosing to review them?
A Not to tell her that those information -- that that [66] information is available; I don't see that that's traumatic at all.

Q Now, there's been an argument made that by having either the physician or counselor advise the woman that this information exists, particularly in the context of alternative organizations that offer an option -- an alternative to abortions, that this would create an impression that the physician approves of the list of facilities and interferes with the doctor-patient relationship. Do you agree with that?
A No, I don't think it means that the physician necessarily approves of it and the physician can qualify the information in any way he or she chooses in the provision of that information.
Q Does your reading of the act prohibit a physician or abortion clinic from disagreeing with the Department of Health's information?
A No, it doesn't.
Q Does it prohibit an abortion clinic or a physician from offering additional information?
A It does not.
Q There's also been an argument made that Section 3205 of the act discourages physicians or counselors from giving additional information beyond what is required in that section; do you agree with that?
[67] A I do not.
Q Why is that?
A Well, it seems to me the act simply provides the minimal things that must be offered to the patient. It does not exclude other counseling, it does not inhibit or exclude other information being given to the patient at the discretion of the counseling physician or health provider.
Q If a physician or counselor believed that additional information should be provided to a woman, other than what's contained in the act to obtain her informed consent, would it be ethically proper to not provide that information?

A No, it would be ethically proper to provide it, if I understand the question. That information should be provided if the counselor or physician feels that's important information for the patient.
Q And do you feel it's ethically improper if that information then wouldn't be provided?
A I do.
Q The pieces of information we've discussed such as the risk of procedure, telling the woman that information about fetal development exists, medical system, benefits may be available, there are organizations that offer alternatives to abortion and the father may be liable. Now, in your experience counseling women, have you had some women that have found any of those pieces of information important?
[68] A Yes.
Q Have some women found each -- each one of those or all of them important?
A Uhm, I'll have to be -- being precise about it, I can't tell you in each specific type of information, but most commonly, the knowledge that there are organizations which will provide support for them and assist in carrying the pregnancy to term, both financially and with counseling support and so forth, have often been important to patients. The specific notification of a -- the husband, not the husband or the father of the child's requiring support, I simply have not been in a situation where I have counseled about that, I have not been aware of that, but that doesn't mean it wouldn't be important information.
Q There's been an argument suggested that if you give a woman too much information in the informed consent procedure that this disempowers the woman. Do you agree with that?
A I do not.
Q Why?

A Well, it seems to me information and especially information about risks, about alternative procedures, about what's involved is essential to an adequate decision about an important event such as termination of pregnancy, and it doesn't disempower but it empowers a patient to make that appropriate decision, so I cannot agree with that statement.

[69] Q Now, you're aware that the act requires physicians to provide certain information 24 hours before an abortion procedure?

A Yes.

Q And you generally agree that informed consent is best face to face?

A In -- yes, whenever possible I think it is.

Q Now, if a Court would hold that the act does not require the initial provision of information under Section 3205(A)(1) to be face to face, but there is -- but is provided by telephone and then the woman would come to the abortion clinic and see either a counselor or doctor the following day and then meet face to face to review informed consent materials, do you believe that would satisfy the informed consent preference to have a face-to-face meeting?

A I think it would probably suffice -- it would -- it would fulfill that qualification. Let me qualify that by saying as long as the patient had been provided with the facts and the information ahead of time and that the face-to-face presentation eventually occurs, which it should, in some setting and if it's with the physician or health care provider in the second situation, I think that would be appropriate.

Q With an informed consent do you consider a 24-hour waiting period to be beneficial?

[70] A Yes.

Q Why is that?

A I think that there is a very serious decision having to

be made and the time to assimilate and digest, if you will, and consider the information that's been provided is beneficial to making that, to making an appropriate decision. One example of a similar type of situation when the -- the Medicaid provisions require that women having sterilization procedures must wait 30 days from the time they have initially made a decision and been informed about it until they make a final decision before they can have a sterilization procedure. Now, that's a 30-day waiting period because it's felt to be an important -- a decision of such importance. And that's regarded as being very straightforward now, we do that all the time.

Q So do you consider time to be an important part of informed consent?

A Yes, time to consider the facts.

Q Now, if you performed abortions in non-life-threatening situations, if a woman arrived at -- before you and she made up her mind to have an abortion, would you still go to informed consent materials?

A Yes.

Q And why is that?

A Well, if I were performing the procedure, as in the case [71] of performing any procedure, I would want to be confident myself that the patient understood the facts and had had access to the information. An exam-- if a patient came in for a -- I'm not talking about abortion now, but a procedure in which she had made up her mind, let's say a mammoplasty or a procedure which she felt certain that she wanted, I still think she's entitled to know all of the facts and risks and alternatives to that procedure before it's performed. And it's incumbent on a physician to perform -- to provide informed consent in that way.

Q You said mammoplasty, could you tell us what that is?

A Well, this is -- I used that procedure only because it's

a procedure which a patient may have decided, it's a cosmetic procedure, a breast augmentation, but a patient may be very much convinced in their own mind that they want that done, but they're entitled to knowing before it's done what the risks are of having it performed.

Q Now, does Pennsylvania's informed consent requirements in its Abortion Control Act a departure from the usual practice, the informed consent?

A Yes, it is. It involves things which are not required in other informed consent.

Q Do you consider that departure to be unnecessary or burdensome?

A No.

[72] Q Why is that?

A It seems to me by the -- by virtue of what is stated very early on in the act, that the State of Pennsylvania has an interest in the health of the mother and the unborn child, that this decision by the patient is of such importance that these additional requirements are certainly reasonable and not burdensome in providing medical care to that patient.

Q Now, Monday Dr. Grodin testified regarding therapeutic privilege where it is proper in some cases to withhold certain information in informed consent process where a patient might have a serious reaction to that information. Are you familiar with that doctrine or privilege?

A I think I understand what -- what you're referring to.

Q What is you understanding of when the therapeutic privilege is applied?

A Well, I think it's -- a physician must make a judgement in some cases about whether informed consent to its fullest extent would really be beneficial to the patient. Let me give you an example. If a patient is -- has, let's say, serious preeclampsia, which we have described before in this testimony, and had it so seriously

that the alternatives of allowing the pregnancy to continue to term would be almost certainly, meant the death of the mother, it seems to me at that point that it is the physician's prerogative to modify the informed consent and not go into all of the risks of [73] continuing pregnancy, which are death. See, he doesn't have to -- that's a very limited informed consent, but it's sufficient, it seems to me. And that I would see as therapeutic privilege in modifying the informed consent, based on the risks involved in providing it.

Q Now, in the context of abortion, do you have an opinion whether therapeutic privilege should apply in non-life-threatening situations?

A Well, in non-life-threatening situations I believe that the patient's entitled to all the information to make an informed consent. I don't see that it would necessarily apply there.

Q Could I have you look at Page 10 of the act, Section 3205(C)? The last line of Section C and it reads: "No physician shall be guilty of violating this section for failure to furnish the information required by Subsection (A) if he or she can demonstrate by a preponderance of the evidence that he or she reasonably believed that furnishing the information would have resulted in a severely adverse effect on the physical or mental health of the patient."

Does that provision offer the therapeutic privilege in those cases which would apply in abortions?

A It certainly does.

Q And could you explain that?

A Well, I think again it's providing the physician the [74] option of exercising good judgment in the care of a patient and to assess the patient's -- the effect of this information upon the patient's physical and mental health. That seems to me a perfectly reasonable exception which provides the physician the opportunity in

some case to not provide all the information, and that certainly is a very reasonable exception here. Now, physicians might disagree about what is or is not to be included, but it allows the physician, under good faith, to use his judgment to do so or her judgment.

Q And just briefly going back to the issue of fetal development and informed consent, does a fetus at nine weeks gestation, LMP, measured from the last menstrual period, have hands and fingers?

A Yes.

Q Could you say when there's the beginning of development of organs in a fetus?

A Well, the development of a fetus is a continuum, if you will, and organ development is occurring really from quite an early stage after the -- after conception, but virtually all of the organ systems have developed to the point that they cannot be altered in a major way by chemicals, by radiation and so forth, by the 56th day of embryonic life, that's eight weeks.

And up to that point they are in various stages of development to the point, but even by five to six weeks of [75] life, fetal heart motion can be detected. At six to seven weeks we can see with an ultrasound scanner a great deal of detail of fetal development, fetal motion, fetal movement, fetal heartbeat, the gastrointestinal system is intact. The central nervous system is developing, it is not completely developed, it isn't even completely developed at the time of birth. But all of these things are in various stages of their development.

Q And would there be a time when the feet and toes are also developed?

A Well, they are developing in this continuum. The limb buds by four weeks are evident and by six weeks the definite fingers and feet and arms and legs are quite distinguishable as separate entities.

Q Now, regarding informed consent regarding a minor

and a parent, there has been testimony it is best to have that parental consent face to face; do you agree with that?

A I would agree with that.

Q Now, if a parent can't come, however, and the law permits consent by telephone or unsworn declaration, would that be acceptable?

A I think it's acceptable in circumstances, yes.

Q Why is that?

A Well, there may be situations where the parents are not immediately available in person, just as there are when we [76] care for children in other settings and we have to proceed with medical care, an accident in which a child is seen and the parents may be away, a child at camp, let's say, has to be treated.

We often are in situations where information must be gained from the parents or their consent by phone. It's simply a situation where the parent is not immediately available and can't be available for a face-to-face presentation of the facts.

Q There has been testimony that if the act goes into effect that there will be stress upon physicians. Do you agree with that statement?

A It's how the act is perceived by physicians, but it seems to me that physicians work under stress all the time. Their very daily care of patients, particularly in obstetrics and gynecology, is fraught with stress.

The decisions about -- are all subject to peer review, they're subject to liability concerns and that's a stressful situation. It's my opinion that this act would not substantively increase that, unless it is how a person individually would interpret them, which I think is a misinterpretation.

* * *

[78] Q Now would a pertinent physician always perform a sonogram in determining gestational age?
A No.
Q Dr. Bowes, is the practice of obstetrics and gynecology, maternal fetal medicine any different, to your knowledge, in Pennsylvania as it is in North Carolina?
A No.
Q Anywhere in the United States?
A No, the standard of care prevails throughout the United States.
Q There was questioning by Mr. Zemaitis about whether you belong to the Association of -- Pro Life Association of Obstetricians and Gynecologists?
A Yes.
[79] Q Would your personal views regarding the issue of pro life ever effect your professional judgment for the provision of medical care?
A No.
Q Would it ever effect how you testify?
A No.
Q Would it ever effect how you teach medical students?
A No.
Q Have you been able to publish medical articles and peer review journals?
A Yes.
Q And your personal views have never interfered with those publications?
A It never interfered with the -- no, the publications of journals, no.

* * *

[80] BY MR. ZEMAITIS:
Q Dr. Bowes, you do practice currently in North

Carolina?
A Yes, I do.
Q North Carolina doesn't have a law making it a crime to fail to give specific pieces of information for informed consent to abortion patients; does it?
A No.
Q North Carolina doesn't have a law making it a crime to fail to delay 24 hours between the time of giving information and performing an abortion; does it?
A No.
Q North Carolina doesn't have a law making it a crime if a counsellor and not a physician gives information for informed consent; does it?
A No.
Q North Carolina doesn't have a law mandating the suspension of a physician's license if he or she fails to get a written statement from a woman stating that she notified her husband of her intent to get an abortion?
A No.
Q North Carolina doesn't have a law mandating the suspension of a physician's license if the physician fails to get the informed consent of both the parent and the minor woman before the minor woman could obtain an abortion; does it?
[81] A No.
Q North Carolina doesn't have a law requiring suspension of the license if the physician doesn't make an accurate determination of gestational age or fails to report the basis for that determination to the State of North Carolina; does it?
A No.
Q North Carolina doesn't have a law making it a felony for a physician to fail to take the specific steps outlined in the Pennsylvania statute when abortion occurs after 24 weeks of gestation; does it?
A No.

Q Now Dr. Bowes, North Carolina doesn't have a law making it the criminal liability of the physician depend upon whether or not medical emergency exists; does it?
A No.
Q You would agree that the definition of medical emergency -- in fact, you did in direct examination agree that the definition of medical emergency in the Pennsylvania statute differs from other definitions commonly used in the medical profession?
A Yes.
Q Have you ever seen a definition that makes a set of circumstances an emergency when a major bodily function is involved, but not a minor bodily function?
[82] A I don't know.
Q Are you aware of any situation where the criminal liability of a physician depends on the major bodily function and minor bodily function?
A No.
Q Have you ever seen a definition that makes a set of circumstances an emergency when it threatens an irreversible impairment, but not a reversible impairment?
A No.
Q Are you aware of any situation where the criminal liability of the physician depends on the determination of whether an impairment will be irreversible?
A No.
Q Have you ever seen a definition that makes a set of circumstances a medical emergency when it threatens a substantial impairment but not an insubstantial impairment?
A No.
Q How do you distinguish between a substantial impairment and insubstantial impairment?
A I think that's a matter of a physician's judgment and experience.

Q Are you aware of any situation where the criminal liability of a physician depends on the physician's determination of whether impairment will be substantial?
A No.
[83] Q Have you ever seen a definition that makes a set of circumstances a medical emergency when it threatens a serious risk of substantial impairment, but not a less than serious risk?
A Well, the -- I can't tell you the specific example, but certainly a medical emergency does involve the assessment of the degree of risk. By it's very nature, emergency involves how quickly and to what degree care must be provided. And that is based on the seriousness of the condition or the seriousness of the potential complications of the condition.
Q So you would agree, Dr. Bowes, that determining the seriousness of the risk is a judgment call for the physician?
A Yes, by all means.
Q Now I think you testified in your direct examination that doctors have gotten concerned and somewhat more cautious in the practice of medicine as a result of liability for malpractice --
A Yes.
Q -- is that a fair characterization?
A That's a fair characterization.
Q Wouldn't you agree, Dr. Bowes, that the imposition of criminal liability for practice of medicine in certain situations would make doctors even more cautious?
A It might make them more cautious, yes.
Q And wouldn't you agree that the additional imposition of [84] criminal liability would increase stress on the practice of medicine which you agree is already a stressful profession?
A It might increase stress, yes.
Q Now you talked about the benefits that you see for a

24 hour waiting period. Is there any medical reason to delay a procedure -- any medical procedure -- for 24 hours once the patient has given informed consent?
A There might be medical reasons to delay based on availability of operating rooms, the availability of care, but apart from that, no.
Q Are you aware of any procedure other than sterilization, which you mentioned, where patient should be forced to delay the procedure once the patient's informed consent is given?
A No.
Q What about a caesarian section?
A The situation -- let me be more specific. The situation where a patient has a choice, there are risks of a vaginal delivery and there are risks in the caesarian section, it's not a situation where you must do a caesarian section. But the patient has a choice. Would you agree that the patient should be required to wait 24 hours if the patient elects to have a caesarian section?
A No, under those circumstances, I wouldn't.
Q would you agree that in a counselling situation, the information provided to a patient should be balanced?
[85] A Yes.
Q Would you agree that the physician or counsellor should not try to persuade the patient toward one decision or another?
A Yes.
Q Would you agree that the physician or counsellor should not give the patient irrelevant information?
A Yes.
Q So for example, if you had a patient with preeclampsia, you would agree that it's not relevant to tell that patient that she might be entitled to medical assistance benefits if she chooses to carry the pregnancy to term?
A I would agree with that.

Q And you would agree that it's irrelevant for that patient to tell her that the father might be liable to support the child?
A Yes.
Q Dr. Bowes, I believe it's your testimony that parents should be involved in the abortion decision with their child; is that correct?
A Yes.
Q Would you agree that parents should be involved in the decision if the child is about to choose a caesarian section?
A Yes.
Q Are you aware that under Pennsylvania law that a pregnant [86] minor can consent to any medical treatment connected with her pregnancy?
A No.
Q Are you aware that under Pennsylvania law a minor who has already had a child can consent to any medical treatment for herself and for her child?
A I wasn't aware of that.
Q Do you believe, Dr. Bowes, that there are any circumstances in which a woman should be forced to have a caesarian section against her will?
A No, although I will tell you, I don't believe she should be forced by the medical doctor. She may be forced by the courts to have a caesarian section.
Q Under what circumstances should a woman be forced by the courts to have a caesarian section against her will?
A I think if it's decided by the courts that the woman is choosing to not have a caesarian section and that it would seriously impair or eventually result in the death of the fetus and the consequences of the decision would result in that sort of impairment to the fetus, the court might find in behalf of the baby that the woman should have a caesarian delivery.

Q So you believe that there are situations where the life of the fetus should control what medical risks a woman has to expose herself to?
[87] A Yes.

* * *

PATRICIA POTRZEBOWSKI, Defense Witness, Sworn.

DIRECT EXAMINATIQN

BY MS. MERSHIMER:
Q Dr. Potrzebowski, can you tell us who you are employed [88] by?
A Yes, I'm employed by the Pennsylvania Department of Health.
Q And what's your position?
A I'm the Director of the Division of Health Statistics and Research.
Q And how long have you held that position?
A Since 1976.

* * *

Q And can you generally tell us your duties?
A Yes, I supervise the activities of the Division of Health Statistics and Research. Those activities include operating several major data collection systems for the Department of Health, producing statistical reports and responding to data requests and providing statistical support services to other programs within the Department of Health.
Q And before we proceed any further, could you just briefly tell us about your educational background?
[89] A Yes, I have a Bachelors Degree of Science in Biology from Shimer College in Illinois. I received that in 1867. I also have a PhD in Human Genetics from the

Graduate School of Public Health at the University of Pittsburgh and I received that degree in 1974.
Q Now as division director, are you responsible for two sections?
A Yes, the division is organized into two sections. Those are the Statistical Registry Section and the Statistical Support Services Section.

* * *

Q Now what's the role of those two sections as they relate [90] to the Abortion Control Act?
A The Statistical Registry Section is responsible for collecting data under the Abortion Control Act and the processing of that data. The Statistical Support Services Section is responsible for analyzing that data and preparing the annual statistical report.

* * *

[91] Q Now can you tell how the individual form is presently maintained and processed physically within the Department of Health?
A Yes, the individual form, when they are received from the facilities, they're opened by a secretary in the division. She date stamps the cover sheet of the form and puts them back in the envelope. They are then taken to the desk of the person in the division who is responsible for processing those forms. Do you need her name?
Q No, it's not relevant.
A Okay, anyway, this person keeps the -- she will review the forms upon arrival. She will check them off on her master list to make sure that each facility has reported -- has submitted their forms that are required on a monthly basis. She will review the forms for

completeness.

She will then enter the forms on a personal computer at her desk, and while she's entering that data, if any questions or problems arise, she may call the facility back to do what we call a query, to obtain additional or clarifying information.

[92] After she is finished entering the data into the personal computer, she would put the forms in a locked cabinet. And anytime that she is not working on those forms, those are kept in a locked cabinet.

Q As to the personal computer, is that password protected?

A Yes, no one may log onto the computer unless they know the password.

Q And how many people know that password?

A In my division, there are currently four people who know that password.

Q And who would that include?

A The person who is doing this work, her supervisor, myself and one other person in the division who is responsible for maintaining a list of all passwords in the division.

Q And am I correct that she uses diskettes with the personal computer?

A That's correct. When she enters the information into the personal computer, that information is put on to diskettes and those diskettes then are also kept in the locked cabinet.

* * *

[93] Q Now what about -- are there any security precautions in preparing the statistical reports so that individual data is not released?

A We would never release any identifiable data on the statistical reports.

Q Well, when it is prepared in the department -- I mean, in the division, I mean, who actually does the statistical report?

A The statistical reports are prepared by the support services section and the people who are involved in doing those preparations would have access to the diskette. As the data were entered onto their computer, again, their computers are password protected so that the information would not be available to anyone other than those -- I believe it would be three people who would be involved in preparing those statistical reports.

Q Now how are the quarterly facility reports physically maintained in the division?

A The quarterly facility reports, again, the envelopes are opened and stamped in by the secretary, put back in the envelopes. The forms are put back in the envelopes. And the envelopes are given to the same person that we discussed before, who processes the individual forms.

She, again, checks off that information to make sure [94] that each facility that is required to file has filed the forms on a quarterly basis. She then keeps those forms -- she checks over the forms to make sure that they are filled out completely and she might contact a facility if the information -- if there is blank information or missing information.

But at that point, then she would put those forms in a locked cabinet and they would not be processed then or analyzed until the end of the year.

Q And how are the complications reports physically maintained?

A The complications reports, again, the envelopes are opened, the forms are date stamped by the secretary, put back in the envelopes, taken to the same person's desk. She again opens them.

In this case, since we don't -- there is no specific -- we do not have a specific number of forms that we

would expect on a regular basis, she doesn't check them off of a list. But she does review the forms for completeness. She conducts any kind of telephone query if the information appears to be incomplete. She keeps the forms in a locked cabinet.

* * *

[95] Q Does the Department of Health have any procedures or guidelines regarding confidentiality in revealing information?
A Yes, the department has general policies and procedures [96] for confidentiality and data release. And in addition, our division has a specific staff manual.
Q Now I'd like to ask you to look at Defendant's Exhibits 41 and 42. Have you seen Defendant's Exhibit 41 before?
A Yes, I have.
Q And could you identify what that is?
A Yes, that is the department's policies and procedures for confidentiality and data release.
Q And could you look at Defendant's Exhibit 42?
A Yes, that is the -- those are selection -- selected pages that relate to confidentiality from our division's staff manual.
Q And are these materials or documents that are used by division personnel in maintaining the confidentiality of information regarding abortion reporting?
A Yes, they are.

* * *

Q Now is your division responsible for maintaining the [97] confidentiality of data in other areas?
A Yes, we are. We are responsible for maintaining confidential information under the Cancer Control Act,

Vital Statistics Act and the Disease Prevention and Control Act.
Q Are you aware of any division employee ever releasing the identity of the attending or referring physician where the woman who had an abortion or facility to the public?
A No, I am not aware of that ever occurring.
Q Now the division releases annual statistical reports; is that correct?
A Yes.
Q Will the division release or reveal the name of the referring or attending physician, a woman who's had an abortion or the facility that's reporting on the individual form in its annual reports?
A No, we would not.
Q Would you ever release that information to anybody else?
A I believe we would not except as the act requires, I believe, under certain circumstances we might release certain information to law enforcement agencies or to the State Medical Board. But I don't believe that information is from the individual form.

* * *

[109] Q Would it be correct to say that Defendant's Exhibit 45 and 46 are the forms that will be available for public [110] inspection if the facility receives Commonwealth appropriated moneys if the injunction is lifted?
A Yes, that's my understanding.

* * *

[111] Q Defendant's Exhibit 49, can you identify that document?

A Yes, this is the directory of social services organizations that was prepared by the department as required by the act.
Q Is this a proposed document if the injunction is lifted?
A It is my understanding that this is the document that would be used, yes.
Q Do you know whether if the department finds out that information was omitted, that it can add to that list?
A I believe that the department would probably update this list and revise it if incorrect -- if there is incorrect information or incomplete information.

• • •

[112] Q Now those additional materials I gave you, Dr. Potrzebowski, can you identify what Defendant's Exhibit 50 is?
A Yes, this is the medical assistance benefits notice that's required under the act.
Q Is this what -- is this a proposed document that will go in effect if the injunction is lifted?
A Yes, this is what would be utilized if the injunction is lifted.
Q And would you turn to Defendant's Exhibit 51? Could you identify that document?
[113] A Yes, these are the other notices that are required by the Abortion Control Act that were prepared by the Department of Health and that the department would plan to use if the injunction is lifted.
Q Is that required by Section 3208 A1?
A I would have to the --
Q Do you know?
A -- act to check the section number, but I know that it's required by the act.
Q So Defendant's Exhibits 48 through 51 are forms that

the Department of Health will use if the injunction is lifted against the act?
A Yes, that is correct.

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BY MS. MERSHIMER:
[124] Q I'd like to ask you a few questions about those. I'd like to ask you, first of all, Ms. Potrzebowski, does the CDC recommend collection of the information that appears on the right hand block of number 13, which is determination of gestational age, type of inquiries, examination, tests utilzed and basis for diagnosis?
A No, I don't believe that the CDC recommends that item. I believe that that was an item that's required by the act.
Q Does the CDC recommend item 14 regarding a medical emergency in its suggested report?
A No, again, that information is required by the act.
Q Now the CDC does recommend that you collect information as to whether or not the patient is married?
A That's correct.
Q But the CDC doesn't recommend information regarding [125] husband notification; does it?
A No, the CDC's information is primarily statistical and so it does not. This, again, is an item that is required by the act.
Q And the second page of that exhibit has three items, 18, 19, 20 -- actually four items -- and 21. None of those items are recommended for collection by the CDC, are they?
A No, all of these items would be required only by -- would be required by the act, but are not recommended by CDC.
Q So the reasons that CDC collects data wouldn't apply

to these items; would they?
A No, well, the CDC doesn't collect data, but the CDC recommendations for collecting data are for statistical purposes and they would not apply to these items.
Q But you referred to the -- I think it's Exhibit 43 --
A The CDC recommended.
Q So to the extent the CDC doesn't recommend these items, the reasons that the CDC offers for its recommendations wouldn't apply to these items; would it?
A That is correct.
Q And you don't intend at this point to make any statistical compilations of determinations of gestational age or the methodology for the determination of gestational age?
A We would plan to make some statiscal compilations relating to gestational age. We do now and we would continue [126] those.
Q And that --
A Though not for the methodology of determining gestational age.
Q And you don't plan to make any statistical studies with respect to the methodology or the bases for the judgment, for example in number 18, the basis for the judgment that abortion was necessary to prevent the patient's death or substantial and irreversible impairment of a major bodily function?
A Well, given that we don't even ask these questions now, I must answer that no, we do not currently have plans. But that does not mean that we would not, in the future, ask -- have plans for statistical compilations for any of these items.
Q But you don't have any at present?
A But we do not have them at present because we are not collecting the information at present.

* * *

Q . . . What have you done now with the 1989 -- the physical reports that were collected for 1989, the individual abortion report?
A The physical forms are currently being kept in -- they have been moved out of the locked cabinets. There were too [127] many of them. They are currently being kept in a secure area, a locked room in -- within the Commonwealth.
Q Within the Department of Health?
A Yes, within the Department of Health but in a different building.
Q Why are they being kept at this point in time?
A They are on our records retention schedule and under our records retention schedule, we are required to keep the hard copy documents for two years.
Q Two years. Do you --
A And then we would -- then we would give them to the records center -- the State records center.
Q Do you know how long the State records center maintains them under the retention schedule?
A I don't recall.
Q Is it -- do they retain them for a number of years beyond the two years?
A Oh, yes, yes.
Q What about the quarterly reports, what happens to those after you draw the information off of them?
A Well, the '89 reports we still have in our office because we're still using them. But they would follow the same records retention schedule. We would maintain them in another locked area for two years and then they would go to the records center.
[128] Q You realize, of course, that the CDC doesn't recommend retaining those documents; don't you?
A I am not aware that the CDC makes that

recommendation.
Q Well, why don't you turn to the page number three. It's the fifth page of Exhibit 43. Do you see at confidentiality?
A Yes, I see it under confidentiality. However, my only concern about that would be that under the act, I believe that we have to make the hard copy documents available to the State Medical Board. And if we would destroy the documents, we could no longer make the hard copy documents available to them.
Q I understand that, I'm just saying though, you would agree, wouldn't you, that that's inconsistent with the CDC recommendation?
A In so far as that the CDC only deals with statistical uses of the records and not any other uses, that is inconsistent.
Q What are the other uses, besides statistical?
A Well, I assume that the medical board would use them. I mean, I cannot tell you for certain what the intent was in putting that provision in the act, but there must have been a reason for requiring them to be released to the medical board upon their request.

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[131] Q You testified that you need information from three reports to get the total number of pregnancies that are occurring. Even that information, though, doesn't help give you the total number; does it?
A You're correct, that does not include the fetal deaths that occurred prior to 16 weeks of gestation.
Q So if a woman has a spontaneous abortion prior to 16 weeks --
A In the first trimester, yes. Or --
Q Your statistical compilation wouldn't gather that information?

A That's correct.

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[132] Q You testified about the process of a query when a report is filed with the Department of Health and that the person who receives the report would contact the facility for additional information.
[133] Isn't it true that each facility has a contact person that the Department of Health deals with for that information?
A Yes, that is correct.
Q And isn't it true that the Department of Health doesn't deal directly with physicians at those facilities for that information?
A We have had to contact physicians directly upon occasion. In general, we generally deal with the contact person in each facility.
Q Have you ever had to contact a physician at a facility where you had a contact person?
A Yes, we have.

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[134] Q Can you tell me why the Department of Health feels it's necessary to state above the signature line, "I understand that any false statement made herein is punishable by law" and then below the signature line, in all capitals "notice, any false statement made herein is punishable by law"?
A My understanding of that is that the law requires that that specific quotation be on the form, but that it was felt that it should also be above the signature.
Q And this Exhibit 48, this is the form that a woman has to sign with respect to husband notification; isn't it?
A That is correct.

Q So the Department of Health thought it was necessary to [135] state twice to a woman in filling out that form that if she provides false information it's punishable by law?
A I don't believe that the Department of Health felt that it had to be stated twice, just that the Department of Health felt that the statement should be made above the signature line, but that the law also required that the specific, exact words "notice" and the rest of that statement be included.
Q And that would have to go below the signature line?
A I don't know where it would have to go.

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[143] JEAN A. DILLON, Plaintiff's Witness, Sworn.

DIRECT EXAMINATION

BY MS. KOLBERT:
Q Ms. Dillon, have you ever been married?
A Yes, I have.
Q And when were you married?
[144] A I was married from 1973 till 1989.
Q Have you ever been a victim of domestic violence?
A Yes, I have.
Q And can you tell the Court when that domestic violence began?
A The domestic violence began in -- around 1976.
Q And how are you -- how did the domestic violence begin, can you explain?
A Yeah, I was -- well, I had been married in '73. I had a child prior to my marriage that my husband adopted. We had a baby together that we both wanted and in 1976 I became pregnant with what would be our second biological son. And--
Q Let me just make sure I understand, that would be your third child; is that correct?

A My third child, yeah. And my husband didn't want me to have the baby. He -- when he found out I was pregnant, he told -- he said it wasn't his baby and I tricked him and he didn't want another child. And I eventually decided that I was going to have the baby. And his way of dealing with that was to not to speak to me for about three and a half weeks.
Q Let me go back a second, Ms. Dillon.
A Mm-hmm.
Q Prior to the time that you were pregnant with your third child, have there ever been any psychological abuse?
A No, I thought we had a pretty good marriage and were [145] really pretty together and happy.
Q Had there ever been any verbal abuse prior to that time?
A No.
Q So to your best recollection, the abuse within your marriage began when you were pregnant with your third child?
A Yes.
Q And what form did it take from then on?
A Well, at that time, like I said, it became -- this silence thing that he developed became pretty -- a way of dealing with me.
Q Now when you say silence, what do you mean?
A Well, lots of times he would come in on a Friday evening from work and we would have a good time together, talk and laugh and share and make love and Saturday morning we would wake up and he wouldn't be speaking to me and wouldn't speak to me for as long as a week. And that was really hard for me, because I didn't understand what that was all about.
Q Now these periods of silence, would they go on and off for periods of time?
A Yeah, he did that a lot to me.

Q And when they -- when you say he did that a lot, about how frequently?
A Uh...
Q Would it occur about once a month, once a year?
A Well, originally about once a month. He really got -- [146] towards the -- of course, towards the end of the marriage it became more intense.
Q Now were you employed at the time?
A My husband and I had our own business together.
Q And what kind of business was it?
A Contracting, paint contracting.
Q And did you go to work together every day?
A Yes.
Q During the periods of silence when you say your husband didn't talk to you, did he talk to you at work?
A He didn't talk to me at work. He would talk to the secretaries, but he wouldn't talk to me at all. I mean, he just didn't talk to me at all. It was no talking.
Q Would you know why the periods of lack of communication began?
A Would I know why, no.
Q And would you know why they would end?
A No.
Q And they could last sporadically for period of time and it was up to him about how they long they lasted?
A Yes.

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[147] Q Now you stated that the abuse began when you were pregnant with your third child. What forms other than the silence did the abuse take?
A Well, the abuse escalated when I became pregnant with my fourth child. And at that time the abuse became physical and verbal. For instance, I can remember being pregnant and being quite large in the

belly and being thrown against the kitchen sink and being afraid of losing my baby.
Q Now were there any injuries sustained when he threw you against the sink at that point in pregnancy?
A I didn't go to the hospital, I was just very sore from that.
Q Did you start to miscarry in any way at that point?
A I had spotting.
Q Did you have cramping at that point? Were you [148] fearful --
A I remember the spotting and I was -- yeah, and I laid down and I was afraid for a few days that I might lose the baby. He didn't want that baby either.
Q At any point was there physical abuse to you by your husband?
A Well, after -- at that time, that's when it started getting very physical, until I -- from that period, which was -- I had that baby in 1980 at Christmas -- from that period until the end of the marriage, it became very physical.
Q When you say physical, what do you mean?
A I can remember being thrown on the floor in the kitchen and being kicked around with his feet. I can remember being drug from the back room of the office and thrown down the cellar steps while the secretaries were there. I can remember being thrown against the cellar door and smashing my face on the cellar door.

Usually when he hit me it was -- it was either he threw me or he hit me a lot. I remember being, you know, hit with his fists in my chest a lot.
Q And when you say he hit you a lot, where would he hit you?
A Mostly in my chest or if he would throw me on the floor, he would kick me in my legs.
Q Did you ever -- were you ever required to seek medical [149] attention as the result of the abuse?

A Yeah, I went to the hospital several -- on several occasions.
Q Do you recall how many times you went to the hospital?
A I went to the hospital at least five times.
Q Now when you would go to the hospital, what would you tell the hospital about how the injuries were sustained?
A Well, four times that I went to the hospital I would tell them that I walked into a door.
Q Now where do you live, what county?
A I live in Monroe County.
Q And is -- can you describe for the Court what kind of area Monroe County is?
A It's a small town. It's a small town, it's rural.
Q And the hospital that you went to, was it the same hospital every time?
A Yes.
Q And did they know you at the hospital?
A People -- I knew lots of people at the hospital, lots of people knew me and my husband.
Q And the people that you saw in the emergency room each of the times that you went were the same?
A Not always the same people, but people from the town.
Q And each occasion you told them that you had what?
A Walked into a door.
[150] Q At any point that you went to the hospital to seek medical attention, did you ever tell them that you had been hurt by your husband?
A The last time that I went, when he threw me into the door and I thought my nose was broken. I waited about three days and I went to the hospital, I went to the emergency room.

And I decided I'm going to tell the doctor what happened. And the doctor said what happened and I

said my husband threw me into the door in the kitchen and I think my nose is broken. And he looked at me and he said you're not going to get a free nose job out of this and he left the room.
Q And that was his full and complete response?
A They x-rayed me and a nurse came in later and said it's not broken, you can go home.
Q Now, let me ask you this. Prior to the time -- on the fifth time that you had gone to the hospital, had you ever asked for help for the abuse within your family?
A No.
Q And why not?
A Because I was embarrassed, it was kind of embarrassing to me and degrading to me and also I was afraid of how he would react if he found out that I was telling people about our secret, about what he was doing to me.
Q And what were you afraid of?
[151] A I was afraid of more abuse.
Q At the time that you told the doctor the first time, what was your reaction after he reacted in the way you've testified?
A My reaction was that what I suspected was true, that nobody would believe me or that if they did, they would feel it was my fault anyway.
Q When was the next time that you asked for help after this fifth trip to the hospital?
A Well, I left my husband in 1984, October, and I didn't go -- I didn't seek any help until 1987.
Q So would it be fair to say that it was approximately three years after --
A Yes.
Q -- this trip to the hospital that you sought additional help?
A Yes.
Q Now let me ask you this. Was there ever an

occasion when your husband would abuse your children?
A My husband beat my children. He would -- he would kind of -- he and I would get into a fight -- a verbal disagreement and sometimes he would divert it away from me onto them and the next thing I would hear him down in the basement where they had their room hitting them with whatever he hit them with, usually an object.
[152] Q Now I didn't ask you this before, but at the height of the abuse, about how frequently did it occur, to you?
A At the height?
Q Yes.
A Oh, about once a week.
Q And how about to your children, how frequently did it occur at the height of the abuse?
A Probably about once every two or three weeks.
Q Now I'm interested about your husband's responses to the pregnancy. Now you stated at the first pregnancy he wanted you to have an abortion; is that correct?
A Well, my first -- no, my first pregnancy with him he wanted the baby. My second pregnancy with him, he insisted that I have an abortion.
Q And how about your third pregnancy with him?
A The same thing, he wanted me to have an abortion. He did not want another baby.
Q And the instances of silence that you described, did that occur with your third child -- or with your -- I'm sorry, your fourth pregnancy also?
A Yes.
Q And how long did they last after notifying him of the fourth pregnancy?
A The silence?
Q Mm-hmm.
[153] A With the second one it wasn't as bad as with the third, but probably about 10 days. But that -- what kind

of happened later was he just kind of ignored the child when it came and didn't help a bit or participate.
Q Now was there ever a time besides telling the doctor at the hospital that you call the police for assistance?
A Yes, after I -- well, after I left my husband, I got a protection from abuse order and I called the police on several occasions. One time I called and they said that they had lost the order and we would have to wait till Monday. Another time I called and they said the order had expired and we would have to wait until my lawyer called them Monday. They were pretty non-responsive.
One time I -- my husband and I were talking on the phone and he said I'm coming to your house with a gun and I got really scared and really nervous and I thought he would really do it and I called them and I had a PFA and I talked to the State Police and told them what was happening and they said -- the gentleman said to me, call me when you're dead, honey.
Q Was there ever an occasion that your husband beat your children or abused your children after you had left him?
A Yeah, one occasion in particular that was really bad was after I had left, my one -- my first son, who my husband had adopted, was staying with his father and he was beaten with a [154] vacuum cleaner and he was -- I describe it as not black and blue but purple from here to his feet.
Q And when you say here, can you explain to the Court --
A From under his neck, from his whole chest, his back, his here, his legs and to his feet.
Q Now you stated for the Court that you were in the contracting business with your husband. About how much money, approximately, per year did the two of you earn?
A We were making a lot of money. On our last year

together we netted close to 200,000.
Q At the point that you left, did you take any money with you?
A I took $25,000.
Q And did you keep that $25,000?
A No, my attorney advised me to return it, that I would be getting support and that I should return it and I did.
Q From the time that you left until you obtained child support, how long a period of time was that?
A From the time I filed for child support until I obtained it was 18 months.
Q Did you receive any child support from your husband during that period?
A No, not during those 18 months, no.
Q And once you got child support -- let me just ask this first, to your knowledge, did your husband's income remain [155] approximately the same?
A Yes.
Q And about how much child support did you get after you obtained an order of support?
A The final order that I got after the 18 months I received $125 a week.
Q And that was for all four children?
A That was for all four children.
Q Now are you employed?
A I'm employed now, yes.
Q And where are you employed?
A I am employed by Women's Resource of Monroe County, Incorporated.
Q And what is that?
A It's a non-profit organization that provides services to battered women and children in domestic violence situations and sexual assault victims.
Q Before I get into your job duties, I do have one futher question about the abuse.
A Mm-hmm.

Q At any point during your marriage, did your husband force you to have sex?
A Yes, he did.
THE COURT: Would you speak a little louder?
THE WITNESS: I'm sorry, yes, he did.
[156] BY MS. KOLBERT:
Q And when was the first time that you told any person about that?
A The first time I told any person about that was last week.
Q Okay and was that in response to my questions to you?
A Yeah, I told you.
Q Now in your job as a -- with Monroe County Women's Services, what are your responsibilities?
A I'm a counsellor, so I counsel the women and children in domestic violence and sexual assault, such as -- such as rape, incest, marital rape and under domestic violence we work with women that are physically, mentally, emotionally battered and abused.
I also do -- I also do PF -- protection from abuse accompaniment to the courthouse and I shelter women that need safe housing and I do crisis intervention also.
Q And approximately how many people do you speak with per year in this capacity?
A Well, I also -- I work in the office and I work hotline, on the hotline, last year I personally did over 600 hours with women. The year before I did over 600 hours.
This year -- this past year in the office, I probably up to about 1300 hours.
Q Now to the best of your recollection, are some of the [157] stories that you hear on a daily basis in that job similar to those of your own?
A Yeah, a lot of times it hits very close to home.
Q And as a general rule, would it be fair to say that the

women that you speak with have difficulty consulting you about their abuse?
A A lot of women call for appointments and can't get in. A lot of women that finally do get in talk about their fear of being found out for having come to us. A lot of women that I talk with are not allowed out of the house unless their husband is with them, so ...
Q Now when you say they're not allowed out of the house, what do you mean?
A I have talked to many, many, many women that can't even go to Wawa without their husband along with them. So they call on the phone and they don't know how they're ever going to get in to see me. Sometimes I do phone appointments with those women.

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[158] Q Is Monroe County Women's Center where you are working a member of the Pennsylvania Coalition Against Domestic Violence?
A Yes, we are.
Q And can you tell the Court what that organization is?
A That's an organization -- that's a coalition of organizations that provide services to battered women and children.
Q And do you have knowledge about the numbers of women that the full coalition provides services to each year?
A In our most recent fiscal year, which ended in June, the coalition provided services -- 400,000 service hours to 70,000 people, both women and children.
MS. KOLBERT: If I may have a minute?
(Pause in proceedings.)
BY MS. KOLBERT:
[159] Q Now Ms. Dillon, you testified that you

stayed with your husband for a period of almost five years after the abuse began. Can you tell the Court why you didn't leave?
A Well, one reason why I didn't leave was because I had four small children and I had put a lot of effort into the business that we had together. We were finally, after eating beans for a long time, making some money. It was real hard for me to face leaving that and having no job skills, no education.
MS. KOLBERT: Your Honor, may I approach the witness?
THE COURT: Yes.
(Pause in proceedings.)
BY MS. KOLBERT:
Q Ms. Dillon, I've just opened the notebook in front of you to document 49, page 44, which is a listing of social service agencies within Monroe County that is included within information that the Department of Health has prepared that provides social services to pregnant women. Can you look over that list for me?
A I can look over it, there's only four listed here.
Q And are there other services within Monroe County that would be appropriate to help women who may be pregnant?
A One of these listed here isn't in Monroe County, it's in Scranton. And there are many more social service agencies in [160] our area.
Q Okay.
A That should be listed or could be listed.
Q And what would some of those include?
A Catholic Services, Lutheran Services, Women in Crisis, Women's Resources --
THE COURT: You must speak louder, please.
THE WITNESS: Okay, should I repeat them?
THE COURT: Yes.
THE WITNESS: Okay, Catholic Services, Lutheran

Services, Women in Crisis, Women's Resources, to name a few. I'm sure there are more.

BY MS. KOLBERT:

Q Now I would ask you to turn to document number 48 in that same booklet. Could you identify that document for us?

A This is spousal notice certification regarding spousal notice.

Q And have you had an opportunity to look at this document?

A Yes, I have.

Q If you had been given this document prior to receiving health services, do you have a reaction, at the time that you were being battered, how you would have reacted to it?

A My reaction to this would be confusion as to what to do. Whether to tell the truth, what that might mean to me if I did and he found out. If I lied, what that might mean to me [161] if he found out. What it might mean relative to would I be imprisoned. It's a pretty scary document to me.

Q Ms. Dillon, have you ever had an abortion?

A I've had two abortions.

Q And were they legal abortions?

A No, they were illegal abortions.

Q And when did they occur?

A 1966, 1967.

Q Could you briefly -- very briefly describe for the Court what occurred on those occasions?

MS. MERSHIMER: Your Honor, I object on relevancy grounds.

THE COURT: Is this relevant?

MS. KOLBERT: I have one question that will make it relevant, your Honor.

THE COURT: All right, overruled. You may renew the objection later, if you wish.

THE WITNESS: I was -- well, I was in college and I was living with my boyfriend and at that time there was no birth control and I got pregnant and sought -- twice sought abortions in Washington, DC and -- do you want me to describe what happened there?

BY MS. KOLBERT:

Q Very, very briefly.

A Okay, well at that time I went to the doctor's office in [162] Washington. You were not allowed to have any anesthesia. I was not allowed to make any noise at all. I was told very forcefully to keep my mouth shut. And afterwards -- immediately afterwards was basically given a pad and asked to leave.

Q Now Ms. Dillon, as a result of those illegal abortions, did you ever suffer any post-abortion stress or suffer from post-traumatic stress in any way?

A No, my reaction to the abortions was relief.

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[163] Q When you talked about 70,000 women and children that were victims of domestic violence in 1988/89, is that the correct number?

A. 70,000 recipients of services from PCADV member organizations.

Q Well, what does that mean, recipients of service?

A It means women and children and significant others that [164] have been or are currently in a domestic violence situation.

Q And does domestic violence include physical violence along with psychological coercion?

A Yes.

Q And do you know how many of these 70,000 service recipients were battered women?

A I don't know that in my head, I have those statistics written down, because they mail us -- mailed us those.

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MS. KOLBERT: Your Honor, we will stipulate to the number if it is helpful to counsel.

THE COURT: Will that --

MS. KOLBERT: Would that be helpful?

THE COURT: -- take care of the matter?

MS. MERSHIMER: I'd just like to know the number.

MS. KOLBERT: The number is 59,912 battering victims, 8,078 children and 4,042 significant others.

BY MS. MERSHIMER:

Q Now Ms. Dillon, do you know of those 59,900 -- were any [165] of those 59,912 battering victims, does that include women, is that what it's focusing on?

A Yes, that's what it's focusing on.

Q I mean, there's just no men involved in that number?

A I personally haven't worked with any men. I'm not saying that there's not one or two men in that number, but --

Q Fine. Do you know how many of those battering victims that were married?

A No, we don't -- I don't have that statistic.

Q And do you know -- so then you wouldn't know how many were married and pregnant?

A No, I don't know that.

Q And you wouldn't know how many were married, pregnant and wanted to have an abortion?

A No.

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